STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676471	A. BUILDING _____ B. WING _____	**06/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all necessary documentation of discharge was in the medical record for one (Resident #1) of ten residents reviewed for transfer/discharge. The facility did not have documentation of a 30-day discharge letter for Resident #1 in his record. This failure could place residents at risk for not receiving care and services to meet their needs upon discharge. Findings included: Resident #1's quarterly MDS Resident assessment dated [DATE] revealed he was a [AGE] year-old male re-admitted to the facility on [DATE] from the hospital. His Brief Interview for Mental Status score was 12 indicating mild cognitive impairment. His functional status included the need for extensive physical assistance of one to two staff for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. Resident #1's active [DIAGNOSES REDACTED]. The MDS Assessment reflected the resident expected to remain in the facility and did not have discharge plans back into the community. Review of a care plan for Resident #1 with a revision date of 5/3/20 reflected short and long term memory loss, verbal, physical, and manipulative behaviors, refusal of care, difficulty feeding himself, risk for falls, required extensive assistance with ADLs, pressure ulcers, [MEDICAL CONDITION] and supra-pubic catheter use. Review of the nursing progress notes for Resident #1 dated 6/15/20 reflected the resident wheeled himself to the front door and forced it open and left the facility. The nurse was unable to find the resident when she went outside and called the administrator, the physician, Resident #1's brother, and the police. Review of the NP's discharge summary dated 6/15/20 reflected the discharge reason was the resident left the facility Against Medical Orders. Review of Resident #1's record on 6/18/2020 reflected that there was no 30-day discharge letter issued to the resident. During an interview on 06/19/20 at 5:21 PM, Resident # 1 stated he was upset about the way the nurse was talking to his brother and he just needed to get out of the building. He stated something in the event triggered his [MEDICAL CONDITION] and he did not know what he was doing, he just needed to get out. He stated he left the facility and the emergency medical service team found him and took him to the hospital. He stated while he was in the hospital, the facility told him he could not return. He stated the social worker at the hospital helped him find a new facility and he will discharge to another facility when he is well enough to leave the hospital, because did not want to go back to a facility that did not want him. During an interview on 6/19/20 at 12:58 PM, Interim Administrator stated he consulted with the physician when he arrived in the facility the next morning and the physician recommended discharging the resident, as the facility was not a safe environment for him if he was able to open the secured doors. Review of the facility policy titled Transfer and Discharge Rights dated June 14, 2006, stated in part Prior to discharge or transfer, the following procedure will take place: The facility must notify the Patient and, if known, a family member or legal representative, of the transfer or discharge and the reasons for the move. This notice will be in writing, in a language and manner that they understand. The facility staff (Social Services) will record the reasons for transfer in the Patient's record. Social Services will also discuss with the Patient and family member/legal representative (if one is available), the alternatives available for transfer and discharge resources in the community. This discussion and all other discussions regarding transfer of discharge will be documented by Social Services in the Patient's medical record. Written notice of transfer must be made by the Facility at least 30 days before the Patient is transferred or discharged . F 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish and follow a written policy on permitting residents to return to the facility after they were hospitalized for [REDACTED]. The facility failed to establish and follow a policy to allow Resident #1 to return to the facility after a hospitalization , which resulted in the resident having to find another facility to live in once he was discharged from the hospital. This failure could result in residents experiencing psychosocial harm due to inappropriate and unplanned discharges, being discharged without appropriate reasons and documentation communicated to help with the transition of care and being discharged without alternate placement and not having access to available advocacy services, discharge/transfer options, and denying them their rights in the appeal process. Findings included: During an interview on 6/19/20 at 12:58 PM, Interim Administrator stated the facility did not have a policy on allowing residents to return to the facility after hospitalization . Resident #1's quarterly MDS Resident assessment dated [DATE] revealed he was a [AGE] year-old male re-admitted to the facility on [DATE] from the hospital. He was able to understand and be understood most of the time. His Brief Interview for Mental Status score was 12 indicating mild cognitive impairment. The MDS Assessment reflected Resident #1 had no verbal or physical behaviors. His behaviors were noted to not have increased since his last MDS review. His functional status included the need for extensive physical assistance of one to two staff for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. Resident #1 had range of motion impairment on both sides of his lower extremities and used a wheelchair for mobility and could self-propel. Resident #1's active [DIAGNOSES REDACTED]. He had occasional pain, which was treated with scheduled and PRN medication. He received anti-depressant, anti-anxiety, antibiotic, and opioid medications. The MDS Assessment reflected the resident expected to remain in the facility and did not have discharge plans back into the community. Review of a care plan for Resident #1 with a revision date of 5/3/20 reflected short and long term memory loss, verbal, physical, and manipulative behaviors, refusal of care, difficulty feeding himself, risk for falls, required extensive assistance with ADLs, pressure ulcers, [MEDICAL CONDITION] and supra-pubic catheter use. Review of the nursing progress notes for Resident #1 dated 6/15/20 reflected the resident wheeled himself to the front door and forced it open and left the facility. The nurse was unable to find the resident when she went outside and called the administrator, the physician, the resident's brother, and the police. During an interview on 06/19/20 at 5:21 PM, Resident # 1 stated he was upset about the way the nurse was talking to his brother and he just needed to get out of the building. He stated something in the event triggered his [MEDICAL CONDITION] and he did not know what he was doing, he just needed to get out. He stated he left the facility and the emergency medical service team found him and took him to the hospital. He stated while he was in the hospital, the facility told him he could not return. He stated the social worker at the hospital helped him find a new facility and he will discharge to another facility in(NAME)when he is well enough to leave the hospital, because did not want to go back to a facility that did not want him. Review of the NP's discharge summary dated 6/15/20 reflected the discharge reason was the resident left the facility Against Medical Orders. During an interview on 6/19/20 at 12:58 PM, Interim Administrator stated he consulted with the physician and the physician recommended discharging Resident #1, as the

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

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.

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F 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) facility was not a safe environment for him if he was able to open the secured doors.