STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49092 Based on observation, interview, and record review the facility failed to establish and maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections that includes written standards, policies, and procedures for the program for 1 (Resident #1) of 4 residents reviewed for infection control. 1. RN (Registered Nurse) A failed to perform proper hygiene during a routine medication administration for Resident #1. RN (Registered Nurse) A knowingly used a syringe that had its plunger seal fall on the ground to administer medication to Resident #1. 2. RN (Registered Nurse) A failed to perform proper Syringe Protocol during routine medication and tube flushing for Resident #1. RN (Registered Nurse) A knowingly continued to use and/or did not change a syringe that he was aware of that had been used for 24 hours to administer a medication, flushing, and placement check to Resident #1. 3. The facility failed to provide evidence of a written Infection Control Policy. These failures placed residents at risk for spread of infection through cross-contamination. Findings included: 1. Review of Resident #1's Face Sheet dated 3/12/2025 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was not cognitively intact and had a Jejunostomy Tube (J-Tube, a plastic tube placed through the skin of the abdomen into the midsection of the small intestine). Diagnoses included Aphasia following cerebral infarction (Loss of the ability to understand following a stroke), Ileus (Digestive Disease), Pneumonia (infection that inflames the air sacs in one or both lungs), Sepsis (body's extreme response to an infection, potentially leading to organ damage and death if not treated promptly), Shortness of breath, Anxiety disorder (excessive and persistent fear, worry, and nervousness), Pain, Constipation (infrequent, hard, or difficult-to-pass bowel movements), Acute embolism and thrombosis (clot that travels and blocks a blood vessel). Review of Resident #1's MDS assessment dated [DATE] revealed the resident did not have a BIMS score because the resident is rarely/never understood. The MDS assessment documented the resident's feeding tube. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #1's Care Plan dated 3/13/2025 revealed the resident received Peg-tube water flush and Peg-tube feeding every shift. Resident received Levofloxacin 500 mg tablet via G-tube every 24 hours on every morning 7 days. Resident received Morphine Concentrate 100 mg/5mL oral solution 0.25 ml/mL sublingually every 2 hours as needed for pain. Resident received Tramadol 50mg tablet via G-tube every 12 hours as needed for pain. Resident received Propranolol 10 mg tablet 2 times per day via J-Tube. Resident received Acetaminophen 325 mg tablet via G-tube every 6 hours. Resident received Finasteride 5 mg tablet via G-tube every evening. Resident received Apixaban 5 mg tablet via G-tube 2 times per day. Resident received Metformin 500 mg tablet via G-tube 2 times per day. Resident received Gabapentin 100 mg capsule via G-tube at bedtime. Observation of video dated 3/11/2025 at 9:46 pm in Resident #1's room revealed Resident #1's family member dropped Resident #1's syringe's plunger seal on the ground. RN A entered Resident #1's room. RN A was told by Resident #1's family member that they had dropped the syringe's plunger seal on the ground. RN A attempted to clean the plunger seal by rinsing it with water before administering medication. At 9:54 p. m. RN A administered medication with the syringe. An interview with DON C on 3/12/2025 at 10:00 a.m. revealed that all nursing staff received in-service training on infection control and j-tube policies. She stated that the staff have been trained how to use piston syringes (a device that is calibrated with a hollow barrel and a movable plunger that is used for feeding tubes and liquid medication). An interview with ADON E on 3/12/2025 at 11:30 a.m. revealed that all nursing staff received in-service training on infection control policies. An interview with RN A on 3/13/2025 at 9:30 a.m. revealed he knew that he should have performed better infection control standards by not using the syringe that had fallen to the ground. He stated that the reason that he used the syringe was because it was the only one available to him at that time. He stated that, although there were other syringes in the facility's central supply, he did not want to get another one from central supply because those syringes belonged to the facility. He stated that Resident #1's syringes were being supplied by Hospice. He stated there would be an infection control risk if using a syringe that had fallen to the ground. He stated that he is not the person who dropped the syringe. He stated that he was not in the room at the time that the syringe's plunger seal had been dropped on the floor. He stated that Resident #1's family member had been in the room prior to him and had been the one to drop the syringe's plunger seal on the ground. He stated that when he arrived to administer medication, Resident #1's family member told him that they had dropped the syringe on the ground. He stated that he attempted to rinse it with water and clean it the best that he could before he administered medication to Resident #1. An interview with LVN F on 3/13/2025 at 10:00 a.m. revealed that all nursing staff received in-service training on infection control policies and j-tubes. She stated that the DON will train you on how to provide j-tube treatment and instruct you to demonstrate it back to her. She stated that anyone who is a nurse should know that you should never use a syringe that has been on the ground. An interview with LVN G on 3/13/2025 at 10:15 a.m. revealed that all nursing staff received in-service training on infection control policies and j-tubes. He stated that nurses are trained to not use a contaminated syringe such as one that has fallen to the ground. He stated there is a big risk of infection if you use a contaminated syringe because it is connected to tubing that goes directly into the stomach. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with Medication Aide H on 3/13/2025 at 10:45 a.m. revealed that she had been trained on infection control and in-serviced. She stated that her job is to strictly pass medications. She stated that if she were to drop anything containing medication on the ground that she would use to pass medication then she would have to dispose of the container and get a new one. She stated that she knew using something that had fallen to the ground would be an infection control risk. An interview with Physician D on 3/13/2025 at 4:15 p.m. revealed that there was a risk of contamination or infection if using a syringe that had fallen to the ground. The risk would be small. It is not likely to happen if it is a one time or isolated incident. The risk would increase if it was happening more than one time. It is not best practice or acceptable standards to use medication equipment that had fallen to the ground. On 3/13/2025, at 12:25 PM RN A was observed during a routine medication administration for Resident #3 with a syringe using good technique. 2. Observation of photograph dated 3/10/2025 of Resident #1's syringe bag revealed Resident #1's syringe bag had the date 3/8/2025 written on it. The facility J-Tube policies revealed all equipment used must be changed every 24 hours. The syringe is used in conjunction with the J-Tube to deliver medication, flush the tube, and check its placement. An interview with ADON E on 3/12/2025 at 11:30 a.m. revealed the syringes are supposed to be placed in a bad and sealed. They should also have the date written and changed nightly. An interview with LVN F on 3/13/2025 at 10:00 a.m. revealed nurses are responsible for supplying a new syringe and dated bag for the syringe every 24-hours. An interview with RN A on 3/13/2025 at 9:30 a.m. revealed he knew that he should have performed better infection control standards by not using a syringe beyond the 24-hour timeframe from when it was last used. He stated that the reason that he used the syringe was because it was the only one available to him at that time. He stated that, although there were other syringes in the facility's central supply, he did not want to get another one from central supply because those syringes belonged to the facility. He stated that Resident #1's syringes were being supplied by Hospice. He stated there would be an infection control risk if using a syringe beyond the 24 hour allotted timeframe. He stated that there was a lot of confusion during the dates of 3/8/2025 - 3/11/2025 as to whether or not Resident #1 was still actively receiving hospice care. He stated that he was informed that Resident #1's family may have revoked hospice and he did not know which materials to use for Resident #1. He did not know if he should use the facility's central supplies or if Hospice was responsible for Resident #1's materials. An interview with LVN G on 3/13/2025 at 10:15 a.m. revealed syringes should be changed every 24-hours or as needed. An interview with Physician D on 3/13/2025 at 4:15 p.m. revealed that there was a risk of contamination or infection if using a syringe beyond the 24-hour window. The risk would be small. It is not likely to happen if it is a one time or isolated incident. The risk would increase if it was happening more than one time. It is not best practice or acceptable standards to reuse equipment beyond the 24-hour timeframe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/13/2025, at 12:25 p.m. RN A was observed during a routine medication administration for Resident #3 with a syringe. The syringe bag was properly dated. 3. Review of the facility's Infection Control policy could not be completed because it was not provided before or after exiting the facility. Attempts were made via email and face to face with the facility Administrator and Director of Nursing on 3/12/2025 and 3/13/2025. In an interview on 3/12/2025 at 9:30 a.m. Administrator B stated that he would provide the facility's infection control policy as requested. Review of an e-mail dated 3/12/2025 at 10:19 a.m. addressed to Administrator B reflected the request of the Infection Control Policy. In an interview on 3/13/2025 at 11:00 a.m. Administrator B stated that he would provide the facility's infection control policy as requested. In an interview on 3/13/2025 at 11:30 a.m. DON C stated that she would provide the facility's infection control policy as requested. She stated that the reason for the delay was because of the size of the infection control policy. She stated that the policy is very broad. She stated that the policy covered many topics and was very long. In an interview on 3/13/2025 at 1:25 p.m. DON C stated that she would provide the facility's infection control policy as requested. The infection control policy was not provided prior to exit.