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	01/07/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one of two residents (Resident #1) reviewed for accident hazards/supervision/devices The Facility failed to ensure CNA D used a gait belt correctly when transferring Resident #1 from his wheelchair to the bed and then from her bed back to the wheelchair on 01/06/26. These failures could affect the residents by placing the residents at risk for discomfort, pain, falls, injuries, and skin tears.Findings included: Record Review of Resident #1's Quarterly MDS assessment, dated 09/17/25, reflected an [AGE] year-old female admitted to the facility on [DATE]. She was severely cognitively impaired with a BIMs score of 3. She required moderate assistance with transfers, toileting, and personal hygiene and required the assistance of 1 person. She was occasionally incontinent of urine and frequently incontinent of bowels. She had sustained one fall without injury since the prior assessment. Diagnoses included dementia, diabetes and hypertension. Review of Resident #1's care plan revised on 06/09/25 reflected, Impaired Physical mobility related to .generalized weakness.left sided weakness.right lower extremity weakness.Goal.Resident will maintain or improve physical function in.Transfer.Interventions.Provide appropriate level of assistance to promote safety of resident.Requires assistance of one staff.Requires extensive assistance. In an interview and observation with Resident #1 on 01/06/26 at 9:15 a.m. resident was observed sitting in her wheelchair in her room. She stated she had fallen recently, and the staff and her family have told her she was not to get up by herself. She chuckled and stated she did not think she needed help to go to the bathroom but stated she was trying to keep her family happy and ask for help. In an observation on 01/06/2026 at 9:55 a.m. Resident #1 was observed being assisted from her wheelchair to the bed by CNA D. Resident #1 was able to hold to the side rail of the bed but required extensive assistance to stand up with CNA D holding on to her arm and pulling her up with the back of the resident's pants. Resident #1 was very unsteady and shaky. No gait belt was used during the transfer. CNA D provided incontinence care and then assisted the resident onto the side of the bed. Resident #1 attempted to hold the arm of the wheelchair while CNA D held her under her arm and once again grabbed the back of her pants to try and assist her to a standing position. Resident #1 was not able to completely stand, and CNA D struggled to get her from the bed to the wheelchair. CNA D then had the resident sit back down on the side of the bed and she placed both of her arms around the resident and lifted her from the bed to the wheelchair. In an interview with CNA D on 01/06/26 at 10:10 a.m. she stated they were not supposed to lift residents under their arms because it could cause injury to their shoulders. CNA D stated she tried not to put her hand directly under her arm pit to prevent injury. She stated she did not know she was supposed to grab the back of the resident's paints. She stated they were supposed to use a gait belt but stated she did not see one in the resident's room. She stated she had been trained on gait belt transfers. In an interview with the DOR 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/06/26 at 12:15 p.m. she stated the facility does annual gait belt training with the staff and nursing does the training at the employee's time of hire. She stated Resident #1 was currently on therapy services due to a recent fall and her decline in transfers and standing ability. She stated she required extensive assistance with transfers. She stated it was not acceptable to lift someone under their arm pits due to the potential for injury not only to the resident but also to the caregiver. She stated it increased the risk of falls, fractures and nerve damage. In an interview with the DON on 01/06/26 at 02:00 p.m. she stated she had started with the facility about 3 weeks ago and was still learning the facility's procedures but stated no one should be lifting a resident under their arms or by their clothing. She stated she would expect staff to use a gait belt when transferring a resident. She stated the risk of staff not following the correct procedure for transfers were injury to a resident's shoulders and arm and or the risk of the resident falling. She stated she would be doing one on one training with the CNA and also begin Inservice with all of the staff to ensure staff were providing correct transfer techniques. Record review of CNA D's staff education/ orientation checklist reflected she had been skills checked for gait belt transfers on 06/25/25 and had met the criteria for proper technique. Record review of the facility's policy, ADL Care-Transfer Techniques dated June 2023, reflected, Staff will provide safe and effective transfer techniques for resident in accordance to standard practice guidelines.Transfer from, bed to chair.Use stand-and-pivot technique with one caregiver if appropriate.Apply gait/transfer belt snugly and low so it circles the resident's waist.Grasp transfer/gait belt keeping palms along resident's side.Rock resident to standing position.Maintain stability of the resident's weakened leg with knee.Pivot on foot farthest from chair.Instruct resident to use armrest on chair for support and ease into chair.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, record reviews and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for residents and staff for 1 (Door #1) of 7 entry doors reviewed for environment. The facility failed to safely monitor individuals who gained access to the facility using the posted security code next to Door #1. This failure could affect the safety of all the residents and staff at the facility and diminish residents' quality of life.The findings include: During an observation of the facility's Door #1 on 1/6/26 at 8:35am surveyor saw a 4-digit code posted next to the door by the keypad. Surveyor entered the four-digit code that was posted, the door unlocked, and Surveyor entered the facility. Upon entry there was no one at the front desk and no one in the two halls that led to the nurses' stations to assist Surveyor. There was no alarm that notified staff that Surveyor had entered the building. Surveyor waited for approximately 7-10 minutes, then went to the 2nd office door behind the front desk to notify a staff member that the surveyors had entered the building. During an telephone interview with the Anonymous Staff Member on 1/9/25 at 2:26pm revealed she was very concerned about the safety of the residents, particularly after 4pm when there were no staff by Door #1. The Anonymous Staff Member stated she had had multiple complaints from relatives of the residents and stated one lady had entered the facility late and was concerned about the safety of her loved one because the code was visible to the public and could open Door #1 after hours, particularly closer to midnight. She stated the concern was brought to the Administrator's attention, but he had not provided a response to her complaint. She stated the risk to the residents of Door #1 not being monitored while the code to enter was posted, was someone could have come into the facility with a gun to harm staff or residents and the staff would not know the person was in the building. During an interview with the Social Worker on 1/6/26 at 3:30pm revealed over the summer she had a resident that complained about the safety of the building, related to unknown people in the hall at night talking. The Social Worker stated they talked to staff about allowing personal visitors to the building. She stated there were no staff in the evenings and at night at the front desk and it was the nurses' responsibility to monitor Door 1. The facility had a receptionist by Door #1 during the day throughout the week and weekend. The social worker stated they could stand at the nurses' stations and look down the hall to see if someone was coming down the halls. During an interview with the Director of Maintenance on 1/6/26 at 3:35pm revealed doors at the facility could not have been opened unless the individuals had a code to open the doors. He stated all the doors at the facility, including Door #1, had an alarm and the alarm would sound if someone attempted to enter the doors without the access code. He stated Door #1 had the code posted on the inside and outside so that staff and other individuals could enter the building without issues. He stated he was unsure how the facility monitored individuals who entered the building through Door #1 when the staff was not close to it. He stated once a person entered the code, they gained access to the building and there was no alarm or bell to notify the staff in the building that someone had entered the building. He stated the code had been posted 24 hours a day for several months. He could not recall the exact number of months the code was posted. He stated he was instructed to post the code by Door #1 because family members would come to the building and would jerk the door open causing the alarm to sound and would break the door. He was unwilling to state the risks to the residents of having the code posted outside without monitoring the door and stated, you need to talk to the Administrator. During an interview with LVN B on 1/6/26 at 4:15pm revealed it was the responsibility of all floor staff to keep an eye on who entered the building through Door #1 in the evenings. He stated he only knew when someone entered through Door #1 if they came to the nurse's station because he (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was usually providing care to patients. LVN B stated it would have been a safety concern that anyone could enter the building through Door #1 using the posted code, but it was not his decision to make. He stated he would not have his house unlocked at night and if he was the owner of the facility, he would have Door #1 locked or have a staff member at the front desk. He stated he always locked all his doors because anything can happen, however it was out of his pay grade to decide if the code was posted outside after hours and at night. He stated he would prefer visitors after hours to call the phone number to be allowed to enter the building. During an interview with LVN C on 1/6/26 at 4:35pm revealed no one monitored Door #1 after hours, as she usually worked until 10pm and there was no staff at Door #1. LVN C stated she knew the code was posted to enter Door #1 and anyone could come in, which was a risk for her and the residents. She personally had not felt safe because she did not know when someone came into the building during her shift. She stated she locked her door at her home at night to not allow anyone to come in and would expect the same from the facility. During an interview with ADON A on 1/7/26 at 8:33am revealed there was staff by Door #1 from about 8am to 3:30pm daily including the weekends. ADON A stated when there were no staff in front, by Door #1, and therefore it was everyone's responsibility to monitor Door #1. She stated although staff were busy in the units she was hopeful staff were walking around to ensure there were no random people in the building. ADON A believed it was a safety concern, no one was monitoring Door #1 after hours because bad things could happen. ADON A stated the safety concern crossed her mind when there was an irate spouse who was threatening staff because their loved one passed away. ADON A stated she believed the code had been posted for at least 6 months. During an interview with the Administrator on 1/7/26/ at 10:40am it was revealed the code to enter Door #1 had been posted for several months. The code was posted due to family members and staff forgetting the code. The Administrator stated he had not had any incidents in which having the code posted put people's lives in danger. He stated, In the world we live in anything is a safety concerns and we cannot prevent everything and therefore did not believe it was a true safety concern to the residents. He stated he did not believe there was risk of having the code posted to enter the building without monitoring individuals entering the building. During record review of the facility's policy Resident Rights revised August 14, 2022, reflected Policy: The staff will abide by and protect resident rights in accordance with state and federal guidelines. Procedure: Staff will abide by resident rights as outlined within CMS state Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities. Requested physical environment policy from the Administrator and was provided the Resident Rights policy.