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	05/18/2026

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 - Some	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 observations and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 5 of 20 rooms (Rooms #501, #508, #510, #705, and #712) reviewed for accident hazards. The facility failed to ensure the sharps containers, which were used to store used needles, in Rooms #501, #508, #510, #705, and #712 were not overfilled.This failure could place residents at risk of exposure to bloodborne pathogens.Observation on 05/18/26 at 9:10 AM revealed the sharps container for room [ROOM NUMBER] was overfilled and two syringes were protruding out of the safety flap. Observation on 05/18/26 at 9:13 AM revealed the sharps container for room [ROOM NUMBER] was overfilled, and the safety flap could not be operated. Observation on 05/18/26 at 9:15 AM revealed the sharps container for room [ROOM NUMBER] was overfilled, and the safety flap could not be operated. Observation on 05/18/26 at 9:28 AM revealed the sharps container for room [ROOM NUMBER] was overfilled and had multiple syringes and needles protruding out of the safety flap.Observation on 05/18/26 at 9:30 AM revealed the sharps container for room [ROOM NUMBER] was overfilled and had multiple syringes and needles protruding out of the safety flap. During an interview on 05/18/26 at 9:45 AM, the Wound Care Nurse stated the nursing staff was responsible for changing out sharps containers when they reached the fill line on the container. She stated overfilling the container placed residents at risk of being stuck with a used needle and being exposed to possible bloodborne pathogens. During an interview on 05/18/26 at 9:49 AM, the ADON stated nursing staff and Central Supply staff were responsible for changing out sharps containers before they became overfilled. She stated the risk of an overfilled container, with needles protruding out of them, was a serious risk to the residents, potentially exposing them to blood or infectious materials on the needles. During an interview on 05/18/26 at 1:24 PM, the DON stated all staff were responsible for checking the sharps containers and alerting nursing staff if one needed to be changed out. Nursing staff were responsible for changing out the containers and for not overfilling them. Continuing to force needles into a sharps container that was filled past the fill line placed the residents at risk of being stuck with a protruding needle and exposure to bloodborne pathogens. Record review of the facility's Regulated Waste policy, dated 01/22/24, reflected: Sharps:.3. Wall mounted sharps containers access is at eye level, approximately five feet up.4. Sharps containers are discarded when 3/4 or less filled.

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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(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	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible, or resident preferences indicate otherwise for 1 of 5 residents (Resident #1) reviewed for nutritional status. The facility failed to monitor Resident #1 weight as ordered, resulting in unexpected weight loss of 4.8%. This failure could place residents at risk of unrecognized weight loss and malnutrition.Record review of Resident #1's admission MDS, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included diabetes, post operative spinal surgery, and chronic pain. She was 64 inches tall and her current weight was 189.2 pounds. Resident #1's BIMS score was 15, indicating she was cognitively intact. Her Functional Abilities assessment indicated she used a wheelchair for mobility and relied on some staff assistance with her ADLs. Her Swallowing/Nutritional Status assessment did not indicate the resident required a therapeutic diet. Record review of Resident #1's care plan, dated 05/05/26, reflected she had a nutritional risk related to diabetes, with interventions of administering medications as ordered and monitoring for adverse side effects and monitor blood sugar levels per MD order; and had impaired mobility related to the spinal surgery, with interventions of assist with ADLs and maintain weight bearing status. Review of Resident #1's physician orders revealed an order, dated 04/22/26, Weekly weights x 4 weeks and a diet order for a regular diet.Record review of Resident #1's weight record revealed she was only weighed once since her admission to the facility, at admission on [DATE]. Her weight was 189.2 pounds at that time. During an observation on 05/18/26 at 3:30 PM, Resident #1 was weighed, and her weight was 180.0 pounds. During an interview on 05/18/26 at 9:10 AM Resident #1 stated there was confusion on her diet when she was admitted , and she was out of it for a few days. Once she was more alert, she was able to pick to understand that the facility did not have a diabetic diet, she was to pick options that best fit her restrictions.During an interview on 05/18/26 at 11:10 AM, the ADON stated the facility's policy was to weigh all residents once a week for the first four weeks to establish a baseline. The ADON stated not monitoring residents for weight loss could result in them becoming malnourished. She stated the CNAs were responsible for weighing residents and reporting it to the nurse. During an interview on 05/18/26 at 11:35 AM, CNA A stated they were alerted to a resident needing to be weighed when it populated on the Kardex which they were supposed to check every day. During an interview on 05/18/26 at 1:24 PM., the DON stated all residents were weighed once a week for the first four weeks at the facility. This establishes a baseline, and alerts staff that the resident might not be adjusting to their new environment if they are losing weight. The DON stated unexpected or unrecognized weight loss could lead to a resident becoming malnourished. An interview was attempted on 05/18/26 at 2:00 PM with the Physician via telephone; however, the attempt was unsuccessful. A message was left with no return phone call. Record review of the facility's Weight Monitoring policy, dated 05/19/23, reflected: Residents weights will be recorded and monitored at a minimum frequency monthly.b. Newly admitted and re-admitted residents are weighed upon admission and weekly x4 and then monthly thereafter, unless otherwise indicated by physician's order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews and record reviews the facility failed to ensure pharmacy services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident was done for 4 of 10 residents (Residents #1, #2, #3, and #4) reviewed for medication administration. The facility failed to consistently monitor the blood sugar levels and administer insulin accordingly for Residents #1, # 2, #3, and #4. This failure could place residents at risk of untreated high or low blood sugar levels, resulting in a worsening of their medical conditions. Resident #1Record review of Resident #1's admission MDS, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of diabetes. Resident #1's BIMS score was 15, indicating she was cognitively intact. Her Functional Abilities assessment indicated she used a wheelchair for mobility and relied on some staff assistance with her ADLs. Her Medications assessment indicated she used insulin daily.Record review of Resident #1's care plan, dated 05/05/26, reflected she had a nutritional risk related to her diabetes and was at risk of high or low glucose levels with interventions of administering medications as ordered and monitoring for adverse side effects and monitor blood sugar levels per MD order. Record review of Resident #1's physician order dated 05/07/26 indicated blood sugar levels were to be monitored before breakfast, lunch, and dinner (6:00 AM, 11:30 AM, and 5:00 PM), and insulin administered according to what the level was based on sliding scale a method used to manage blood glucose (sugar) levels by adjusting the insulin dose based on the resident's current blood glucose level). Her sliding scale was 0-199=0u, 200-250=4u, 251-300=6u, 351-400=10u and, 401-450 = 12u and notify MD.Record review of Resident #1's insulin administration record for May 2025 revealed glucose levels were not checked, and her insulin was not administered. on the following dates: 04/24/26 her 6:00 AM glucose level was 216 and treated, her 11:30 check was missed, and her 5:00 PM level was 114, no treatment needed. 05/02/26 her 6:00 AM check was missed, her 11:30 level was 147, no treatment needed. 05/06/26 her 6:00 AM glucose level was 174, her11:30 AM check was missed, her 5:00 PM level was 183, no treatment needed Record review of Resident #1's EHR from 05/01/26 to 05/18/26 revealed no nursing progress noted indicating why the doses were missed. During an interview on 05/18/26 at 9:10 AM, Resident #1 stated staff did not always give her insulin properly. She stated that some days it was checked after she had eaten her meal, and some days it was not checked but once or twice. She stated she would tell the nurses they were not administering her insulin properly, and they would either ignore her or tell her they were following the doctor's orders. Resident #1 stated she did not feel her glucose levels ever got out of control, being too high or too low. Resident #2Record review of Resident #2's quarterly MDS assessment, dated 03/18/26, reflected he was a 74-tear-old male admitted to the facility on [DATE] with a diagnosis of diabetes. His BIMS score was 15, indicating he was cognitively intact. His Functional Abilities assessment indicated he required minimal assistance with his ADLs. His Medication assessment indicated he used insulin once in the previous 7 days. Record review of Resident #2's care plan, dated 03/24/26, reflected he had diabetes and was at risk for high or low glucose levels with interventions of monitoring blood sugar levels as ordered and administer diabetic medicines as ordered. Record review of Resident #2's physician orders revealed *Insulin Lispro was ordered on 3/18/26 to be monitored before breakfast, lunch and dinner (6:00 AM, 11:30 AM, and 5:00 PM). Insulin was to be administered per his sliding scale. His sliding scale was - 60 = 0 UNITS * MD Call, 61- 149 = 0 UNITS 150 - 200 = 4 UNITS, 201 - 250 = 6 UNITS 251 - 300 = 8 UNITS, 301 - 350 = 10 UNITS, 351 - 400= 0 UNITS * MD Call 401 or greater * Lantus was ordered on 03/15/26, was to be administered before breakfast. Record review of Resident #2's insulin administration record revealed glucose level was not checked, and his fast-acting insulin was not administered on the following dates: 05/01/26 at 6:00 AM his glucose was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	216 and was treated, his 11:30 check was missed, and his 5:00 PM level was 213 and was treated. 05/04/26 his 6:00 check was missed and his 11:30 glucose level was 242 and was treated. 05/05/26 his 6:00 AM glucose level was 239 and treated, his 11:30 check was missed, and his 5:00 PM level was 280 and treated. 05/06/26 his 6:00 AM was 218 and was treated, his11:30 check was missed, his 5:00 PM glucose level was 270. 5/11/25 his 6:00 AM glucose level was 215 and treated, his 11:30 AM check was missed, and his 5:30 level was 241 and treated. 05/15/26 his 6:00 AM glucose level was 204 and treated, his 11:30 check was missed, and his 5:30 level was 306. Record review of Resident #2's EHR from 05/01/26 to 05/18/26 revealed no nursing progress notes indicating why the doses were missed. During an interview on 05/18/26 at 2:10 PM, Resident #2 stated he felt like he was not always getting his insulin like he was supposed to, but the nurses said he was. Resident #2 said he would get confused sometimes, so he assumed the nurses were right. He denied having high or low glucose level issues. Resident #3Record review of Resident #3's quarterly MDS, dated [DATE] reflected he was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of diabetes. His BIMS score was 15, indicating he was cognitively intact. His Functional Abilities assessment indicated he was completely reliant on staff to meet his ADLs. His Medication assessment indicated he used insulin daily in the past 7 days.Record review of Resident #3's care plan, dated 03/27/26 reflected he required maximum assistance with his ADLs, had diabetes with interventions of checking blood sugar levels as ordered and administering diabetic medications as ordered, and was at risk of high or low glucose levels with interventions of diet as ordered, and administer medications as ordered. Record review of Resident #3's physician orders revealed as follows:His fast-acting insulin was ordered on 02/04/26, his glucose levels were to be checked before breakfast, lunch, dinner, and before bedtime (8:00 AM, 4:30 PM, 8:00 PM, and 12:30 AM), and his insulin was to be administered according to his sliding scale which was 0-199=0u, 200-250=4u, 251-300=6u, 301-350=8u and notify MD, 401-450 = 12u and notify MD,. His long acting was to be administered at bedtime. Record review of Resident #3's insulin administration record revealed glucose level was not checked, and his fast-acting insulin was not administered. on the following dates: 05/04/26 his 12:30 AM glucose level was 176, no treatment needed, his 8:00 AM check was missed, and his 4:30 level was 198 and treated, his 8:00 PM check was missed. 05/08/26 his 12:30 AM glucose level was 137, no treatment needed, his 8:00 AM check was missed, his 4:30 PM level was 225 and was treated. 05/11/26 his 12:30 AM glucose level was 161, no treatment needed. His 8:00 AM check was missed, and his 4:30 level was 233 and was treated. 05/13/26 his 12:30 AM glucose level was 127, his 8:00 AM check was missed, and his 4:30 PM level was 240 and treated. 05/14/26 his 12:30 AM glucose level was 129, no treatment needed, his 8:00 AM check was missed, and his 4:30 level was 199 and was treated. 05/15/26 his 12:30 AM glucose level was 129, no treatment needed, his 8:00 AM check was missed and his 4:30 level was 145, no treatment neededRecord review or Resident #3's EHR from 05/01/26 to 05/18/26 revealed no nursing documentation of why the doses were missed. During an interview on 05/18/26 at 2:20 PM, Resident #3's interactions were limited due to his disease process. Resident did not express any concern about his medications. Resident #4Record review of Resident #4's quarterly MDS assessment, dated 03/01/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of diabetes. His BIMS score was 4, indicating severe cognitive impairment. His Functional Abilities assessment indicated he was totally dependent on staff to meet his ADLs. His Medication assessment indicated he used insulin daily in the previous 7 days. Record review of Resident #4's care plan, dated 03/13/26, reflected that he had cognitive losses, required assistance with his ADLs, and had diabetes with interventions of check blood sugar levels as ordered and administer diabetic medications as ordered. Record review of Resident #4's physician orders revealed an order, dated 09/22/25, for fast acting insulin to be administered before breakfast, lunch, and dinner (7:00 AM, 11:30 AM, and 5:00 PM) according to his sliding scale which was 0-60= 0 units (Call MD), 61-149= 2 units, 150-199= 4 units, 250-299= 6 units, 300- 349= 8 units, 350 or greater administer 10 units and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notify MD. Record review of Resident #4's insulin administration record revealed glucose levels were not checked, and his insulin was not administered on the following dates: *05/02/26 he was not checked or treated the whole day (7:00 AM, 11:30 AM, and 5:00 PM). *05/03/26 his 7:00 AM glucose level was 178. *05/05/26 his 7:00 glucose level was 237 and treated, his 11:30 check was missed, and his 5:00 PM level was 292 and treated. *05/11/26 he was not checked or treated the whole day (7:00 AM, 11:30 AM, and 5:00 PM). Record review of Resident #4's EHR from 05/01/26 to 05/18/26 revealed no nursing documentation for the missed doses. An interview was attempted with Resident #4 on 05/18/26 at 2:25 PM, but it was unsuccessful. An attempt was made to interview Resident #4's Physician on 05/18/26 at 2:00 PM, but the attempt was unsuccessful. A message was left with no return call. During an interview on 05/18/26 at 2:35 PM, LVN B stated he did not know about residents missing doses of insulin. He stated he monitored the diabetic residents closely in case there was an issue. The missed dates for Resident #4 were reviewed with LVN B, and he stated he was not working on any of the dates. He stated there was a lot of agency staff that worked at the facility. He stated the risk of not checking glucose levels and administering insulin could be high glucose levels, leading to a diabetic coma. During an interview on 05/18/26 at 2:40 PM, the ADON stated missing insulin doses was not allowed. She stated the nurse could always ask for help if they were behind and needed help with their glucose checks and insulin administration. She stated the risk to the residents was either high or low glucose levels. During an interview on 05/18/26 at 2:55 PM, the DON stated missing doses of insulin was not acceptable. She stated the risk of the resident's glucose levels getting too high or going too low was too great. She stated she had no idea doses were being missed. She stated the nurses were responsible for administering all medications as ordered by the physician. Record review of the facility's Medication Administration policy, dated January 2025, reflected: 1. Medications are administered in accordance with written orders of the prescriber.