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	05/28/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 1 (Resident #2) of 8 residents reviewed for accommodation of needs. The facility failed to ensure Resident #2 had their call light within reach. This failure could place residents at risk of not having their needs and preferences met.Findings included:Record review of Resident #2's face sheet, dated 05/28/26, reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #2's Annual MDS, dated [DATE], reflected she was diagnosed with Non-Alzheimer's Dementia (any form of cognitive decline that was not caused by Alzheimer's Disease) and Diabetes Mellitus (chronic metabolic disease characterized by persistent high blood sugar levels). The MDS further reflected Resident #2 had a BIMS score of 3, indicating severe cognitive impairment and required moderate to maximal assistance with ADLs. Record review of Resident #2's care plan, dated 05/28/26, reflected she had a fall on 09/09/25 and 12/15/25 with an intervention to orient to call light and keep within reach. Observation and interview on 05/28/26 at 9:47 AM of Resident #2 revealed her sitting in the wheelchair next to her bed eating breakfast. The call light was observed on the opposite side of the bed, lying on the floor. Resident #2 stated she did use her call light when she could get to it. Resident #2 stated it was usually kept on her bed but was unable to find it during the interview. She stated she could push it when it was located on the bed but could not reach the floor. Observation on 05/28/26 at 10:54 AM revealed Resident #2 sitting in her wheelchair beside the bed. Call light observed on the floor on the opposite side of the bed. CNA D observed assisting Resident #2's roommate behind the closed curtain. Observation on 05/28/26 at 11:47 AM revealed Resident #2 being assisted to use the bathroom with CNA C and CNA D. Observation of Resident #2's call light observed on the floor beside the bed.Observation on 05/28/26 at 1:44 PM revealed Resident #2 in her wheelchair next to her bed. Observation of call light revealed it was on the opposite side of the bed, on the floor. Interview on 05/28/26 at 2:25 PM with LVN E revealed she had worked at the facility since February 2026. She stated she expected the call lights to always be within the residents' reach. LVN E stated the call light was used as a way for residents to ask for assistance from staff. She stated it was all staff's responsibility to ensure the residents could reach the call light. LVN E stated Resident #2 could not reach the call light if it was on the floor. LVN E stated the risk of not having the call light where Resident #2 could reach, was she may not be able to call staff, and something could happen to her. Interview on 05/28/26 at 2:45 PM with CNA C revealed she had worked at the facility for 2 years and was familiar with Resident #2. She stated Resident #2 would not be able to reach the call light if it was on the floor. CNA C stated she was not Resident #2's main aide and only entered her room to assist CNA D. She stated she did not see Resident #2's call light on the floor. CNA C stated all call lights were expected to be within the residents' reach. She stated the risk of not having the call light within reach was that a resident could not ask for help if they needed assistance with something and could potentially have a fall.Interview attempts in person on 05/28/26 with CNA D were unsuccessful. A phone interview attempt was also made at 3:53 PM on 05/28/26; however, there was no answer and no return phone call was received. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/28/26 at 5:34 PM with the DON revealed she expected all staff to put the call lights within the residents' reach. She stated Resident #2 could not reach the call light with it on the floor. The DON stated she expected staff to check every round to ensure the call light could be used if they needed staff assistance. The DON stated the risk of not having the call light within reach was something could happen and Resident #2 could not use her call light for assistance. Interview on 05/28/26 at 6:13 PM with the Administrator revealed he expected all call lights to be within reach of the residents. He stated no call lights should be located on the floor. The Administrator stated it was all staff's responsibility to ensure the call lights were within reach. The Administrator stated the risk of call lights out of reach was the resident could not notify staff if there was a need. Record review of the facility's policy, Call Lights Answering revised 01/19/23, reflected the following: .7. When leaving the room, be sure the call light is place within the resident's reach .

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 receives the necessary services to maintain good nutrition, grooming, and personal hygiene for 1 of 5 residents (Resident #1) reviewed for ADL care.The facility failed to provide Resident #1 assistance with timely incontinence care for approximately 6 hours on 05/28/26, which resulted in Resident #1 being soaked with urine and soiled through her brief, draw sheet, and bed sheets. This failure could place the residents at risk for decreased feeling of self-worth, skin breakdown, and infection. Findings included:Record review of Resident #1's face sheet, dated 05/28/26, reflected Resident #1 admitted to the facility on [DATE] and readmitted on [DATE].Record review of Resident #1's Annual MDS, dated [DATE], reflected Resident #1 had the following diagnoses: Non-Alzheimer's Dementia (any form of cognitive decline that was not caused by Alzheimer's Disease), Seizure Disorder or Epilepsy (condition causing repeated seizures from abnormal brain activity), Anxiety (excessive fear or worry that could disrupt daily life), and Schizophrenia (mental health condition that affects how people think, feel, and behave). The MDS also reflected that she was always incontinent of bowel and bladder and Resident #1 was noted to be dependent on staff for toileting hygiene. Record review of Resident #1's care plan, dated 05/28/26, reflected she was incontinent of bowel and bladder with interventions to, assist with toileting needs; check and change, keep clean and dry; after each incontinent episode apply barrier cream. Observation and interview on 05/28/26 at 10:00 AM with Resident #1 revealed her lying in bed. Resident #1 appeared to be a poor historian at times throughout the interview. Resident #1 stated the staff come in occasionally to check on her. She stated the staff had already changed her and that they change her at least once a day. During the interview, Resident #1 appeared to get irritated and stopped answering questions. Observation and interview on 05/28/26 at 12:53 PM revealed CNA A performing incontinence care on Resident #1. CNA A pulled back the sheets on Resident #1. CNA A observed the sheets and stated she needed new sheets before starting incontinent care. Observation of the sheets revealed the urine in the brief had soaked through to the draw sheet and fitted sheet. Interview with CNA A revealed she had last changed Resident #1 at 7:00 AM. She stated her shift started at 6:00 AM and she did rounds and then started her showers. CNA A arrived back to the room with clean sheets and supplies and began performing incontinence care. When Resident #1's brief was undone, it was observed to be full of urine and feces and had a strong urine odor. When Resident #1 was turned onto her side during incontinence care, it was noted that the urine had soaked through her brief, draw sheet, and fitted sheet. Resident #1 observed to have redness to sacral area with no open areas. CNA A stated the redness was not new and they applied barrier cream to it. Resident #1 denied any concerns during the care and was unable to answer when she had last been changed.Interview on 05/28/26 at 2:02 PM with CNA A revealed she had worked at the facility since 2023. She stated she was expected to perform rounds every 2 hours. CNA A stated when she got caught up in another room, it could take her longer than the 2 hours. She stated not changing Resident #1 for that long was her fault since Resident #1 was assigned to her. She stated it was approximately 6 hours since she had last performed incontinence care on Resident #1. CNA A stated she had poked her head into the room to check on Resident #1 but never looked to see if she needed to be changed. CNA A stated Resident #1 was fully dependent on staff for incontinence care and had to be checked to confirm if she was wet. CNA A stated there was a horrible risk if rounds were not performed every 2 hours. She stated it put Resident #1 at risk of skin breakdown and bed sores. Interview on 05/28/26 at 5:05 PM with LVN B revealed she expected her CNAs to complete their rounds and check the residents at least every 2 hours. LVN B stated she was unaware that Resident #1 went 6 hours without incontinence care. LVN B stated she was assisting CNA A throughout the shift, and she had not asked for help with Resident #1. LVN B stated Resident #1 was dependent and always incontinent of bowel and bladder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN B stated she did check on Resident #1 but was unaware what time. LVN B stated not changing Resident #1's brief when she was wet, put her at risk of bed sores. She stated Resident #1 did have redness that had been there previously and the CNAs were applying barrier cream to it. Interview on 05/28/26 at 5:34 PM with the DON revealed she expected her staff to check and change residents at least every 2 hours. The DON stated it was unacceptable for Resident #1 to go 6 hours without incontinence care. The DON stated it was all staff's job to ensure that residents were being checked on every 2 hours. She stated Resident #1 not getting timely incontinence care placed her at risk of UTI, wounds, and more. Record review of the facility's Perineal care/Incontinent Care policy, dated April 2012, reflected: Staff will perform perineal/incontinent care with each bath and after each incontinent episode.