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	06/12/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 of 3 residents (Residents #1, #2, and #3) reviewed for pressure ulcers.1. The facility failed to provide wound care to Resident #1's left buttocks pressure wound on 05/04/2026, 05/05/2026, 05/14/26, 05/15/26 and 05/22/26 and failed to follow the physician orders for Resident #1 while providing wound care on 06/12/26.2. The facility failed to provide wound care to Resident#2's left buttock on 05/02/26, 05/04/26, 05/05/26, 05/14/26, 05/15/26, 05/17/26, 05/22/26, and 05/28/26 and failed to follow the physician orders for Resident #2 while providing wound care on 06/12/26.3. The facility failed to provide wound care to Resident #3's sacrum wound on 05/07/26, 05/08/26, 05/09/26, 05/10/26, 05/11/26, 05/22/26, 05/23/26 and 05/25/26 and failed to provide wound care to Resident #3's mid back wound on 06/02/26, 06/04/26, 06/05/26, 06/07/26, and 06/09/26.These failures placed residents at risk of developing new or worsening pressure ulcers, infection, and pain. Findings included:1.Record review of Resident #1's comprehensive MDS assessment, dated 03/13/2026, reflected she was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included diabetes and hypertension. Resident #1's BIMS score was 11 which indicated moderate cognitive impairment. The MDS further revealed Resident #1 was at risk of developing pressure ulcers/injuries.Record review of Resident #1's care plan, dated 03/30/26, did not address wound care on left buttocks.Record review of Resident #1's wound care Order, dated 04/24/26, reflected the following: left buttock Cleanse with dermal wound cleanser, pat dry, apply manuka med cover with foam dressing(start [04/21/26 08:09] on day shift".Record review of Resident #1's Order Summary Report, dated 06/10/26, reflected the following: - Coccyx (the tailbone)Wound Cleanse the wound with normal saline (NS). Pat the area dry. Apply Triad paste to the wound/peri wound area Dust miconazole powder over the affected area. Apply calcium alginate dressing. Cover with a dry dressing. ([START 06/11/26 14:07] On Day Shift [Time: Shift 1]) AND ([START 06/11/26 14:07] As needed anytime)".Record review of Resident #1's Wound Care Administration Record for May 2026 reflected the Wound Care was not documented as being completed on 05/04/2026, 05/05/2026, 05/14/26, 05/15/26 and 05/22/26, for Resident#1's dermal wound due to shear friction of the left buttock.Record review of the progress notes for May 2026 reflected there was no documentation of wound treatment for the missed days .Observation and interview on 06/12/26 at 3:15 PM revealed Resident #1 was sitting in her chair in her room. Resident #1 said she had wounds on her bottom, and she got wound care, but she could not tell when. Observation on 06/12/26 at 03:56PM with LVN A, providing Resident #1 with wound care revealed, he disinfected the table and left it to dry . He removed gloves, washed hands, and put the supplies together. He washed hands and put on PPE. He wheeled the table to Resident #1's bedside. He then washed his hands and put on gloves. The dressing was observed off. The family member reported it had fallen when she was using the bathroom. He cleansed the wound with normal saline, removed his gloves, washed his hands, and put on new gloves. The wound was observed almost healed with no (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drainage or signs of infection observed. He applied calcium alginate, but he did not apply triad paste on peri wound area and he did not dust miconazole powder over the affected area as per the doctors' orders and covered with a dry dressing dated 06/12/26.2.Record review of Resident #2's Comprehensive MDS Assessment, dated 05/05/26, reflected Resident#2 was a [AGE] year-old male who initially admitted to facility on 11/03/21 and readmitted [DATE]. His diagnoses included traumatic brain injury (a disruption in normal brain function caused by a sudden bump, blow, jolt, or penetrating object to the head). The resident's BIMS score was not documented due to the resident being rarely/never understood. His MDS assessment indicated he was at risk of developing ulcer/ injuries.Record review of Resident #2's care plan, dated 11/06/25, reflected the following:wound care addressed but not on the left buttocks.Record review of Resident #2's order, dated 04/06/26 with a stop date to 05/17/26, reflected the following: - Left Buttock Cleanse Wound with normal saline, pat dry, apply calcium alginate, cover with dry dressing. ([START 04/06/26 09:21]{Sic} On Day Shift [Time: Shift]) AND ([START 04/06/26 09:21][Sic} As needed anytime). Apply triad paste to peri wound"Record review of Resident #2's order, dated 05/17/26, reflected the following: - Left Buttock Cleanse Wound with normal saline, pat dry, triad paste to peri wound, Gentamicin ointment, manuka med, cover with dry dressing. ([START 05/17/26 15:17][Sic]On Day Shift [Time: Shift 1]) AND ([START 05/17/26 15:17][Sic] As needed anytime)". Record review of Resident #2's order summary report, dated 06/12/26, reflected the following: - Left Buttock Cleanse Wound with normal saline, pat dry, triad past e to peri wound, Gentamicin, Santyl, calcium alginate. cover with dry dressing. ([START 06/12/26 13:55][Sic] On Day Shift [Time: Shift 1]) AND ([START 06/12/26 13:55] [Sic] As needed anytime)".Record review of Resident #2's wound care administration record for May 2026 reflected there were missed entries on 05/02/26, 05/04/26, 05/05/26, 05/14/26, 05/15/26, 05/17/26, 05/22/26, and 05/28/26. The spaces were documented as Missed.Review of the progress notes for May 2026 reflected there was no documentation of wound treatment on the missed days.Observation on 06/12/26 at 03:27PM with LVN A, providing Resident #2 with wound care revealed, he disinfected the table and left it dry . He removed gloves, washed hands, and put the supplies together. He washed hands and put on Personal Protective Equipment (PPE). He wheeled the table to Resident #2's bedside. He then washed his hands, put on gloves, and removed the old dressing on Resident #2's left buttock. The old dressing was observed to be dated 06/12/26. He did not change gloves and perform hand hygiene. He cleansed the wound with wound cleanser, removed his gloves, washed hands and put on new gloves. The wound was observed almost closing and no signs of infection were observed. He applied calcium alginate. He failed to apply triad paste on peri wound, gentamycin and Santyl as per doctors' orders and then covered wound with a dry dressing dated 06/12/26. 3. Record review of Resident #3's Comprehensive MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male. Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included Pressure ulcer of sacral region (a painful wound over the tailbone caused by unrelieved pressure that cuts off blood flow to the skin). Section M indicated open lesion(s)other than ulcers. BIMS score was not documented as residents rarely/never understood. Record review of Resident #3's order, dated 05/05/26 with a stop date of 05/11/26, reflected the following: - sacrum wound cleanse with Dakin's 0.125%, pat dry. Apply Gentamycin ointment and Medi honey to wound bed, pack with Dakin's moist gauze. Cover with dry dressing. (Start 05/05/26 on day shift and start 05/05/26 as needed anytime) twice a dayRecord review of Resident #3's order summary report, dated 05/17/26, reflected the following: - sacrum wound cleanse with Dakin's 0.125%, pat dry. Gentamycin ointment, Medi honey, pack with Dakin's moist gauze. Cover with dry dressing. (Start 05/17/26 on day shift and start 05/17/26 as needed anytime)Record review of Resident #3's order, dated 05/17/26 with a stop date of 06/10/26, reflected the following: - Mid back wound cleanse with normal saline pat dry. Apply Calcium alginate, cover with dry dressing. (Start 05/17/26 on day shift)."Record review of Resident #3's Wound Care Administration Record for May 2026 reflected there were no entries, and the spaces were documented (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as Missed for: 05/07/2026, 05/08/26, 05/09/26, 05/10/26, 05/11/26 , 05/22/26, 05/23/26 and 05/25/25/26. Record review of Resident #3's Wound Care Administration Record for June 2026 reflected there were no entries, for wound care for the mid back on 6/2/26, 6/4/26, 6/5/26, 6/7/26, and 6/9/26 . Record review of Resident #3's care plan, dated 05/27/26, reflected the following:Problem: Skin breakdown. Goals: Measures will be taken to preventskin breakdown. Interventions: Administer skin/wound treatments as ordered.Interview on 06/12/26 at 4:17 PM with LVN A revealed he had not noticed wound care was being missed, because he was not the regular nurse for wound care. He said he knew he was supposed to review orders before wound care. He said he forgot to administer Gentamycin ointment ,triad paste and Santyl on Resident #2 wound on his left buttock/sacrum and miconazole dust on Resident #1 wound on her left buttock. LVN A said the risk of not following doctors wound care orders could lead to wounds getting infected or slow healing processes. An attempt was made to contact Hospice nurse, who was assigned to Resident #3, on 06/12/2026 at 04:52PM by phone; however, there was no answer.Interview on 06/12/26 at 06:07 PM with the Wound Care Nurse via phone revealed she was no longer the wound care nurse; she was fired after facility performed wound care sweep and they found more wounds that were not being addressed. She said she had not noticed wound care was being missed, because she had not paid attention to treatment administration records. She stated she worked Monday through Friday, and she was ensuring she documented wound care, but she was not aware the treatment record was showing as not performed, On the weekend wound care was provided by another nurse. She said Resident 3 had sacrum wounds that he had admitted with and he was on hospice and hospice, and facility staff were responsible for his wound care on his sacrum. She stated Resident #1 and Resident#2 both had wound on their left buttocks due to shear friction. She said she was responsible for ensuring wound care was being done by hospice and by her on Resident#3. She said when she noticed hospice was not performing wound care she reported it to the DON and Administrator. The Wound Care Nurse said the risk of not performing wound care could lead to wounds getting infected or slow healing processes.Interview on 06/12/26 at 06:41 PM with the DON revealed her expectation was all wounds were being treated as per physician orders. She said she expected the wound care nurse to document wound care on the treatment administration record. She stated the wound treatment nurse worked Monday through Friday, and she expected her to sign treatment administration record after wound care. She said when hospice residents get admitted , the facility received wound care orders from hospice, and it was facility's responsibility to put orders in the system and provide wound care. She said Resident #3 missed wound care because the nurse that received wound care orders from hospice put in the system as, as needed orders. The DON said all management teams go through medication administration records and treatment administration records during morning meetings, and they address missing orders and she thinks they missed wound care. The DON said if residents were not receiving wound care as ordered it could lead to increased risk of infection or wounds getting worse. She said if physician orders were not being followed it would slow the healing of the wounds, leading to deterioration and infection.Interview on 06/12/26 at 07:21 PM with the Administrator revealed his expectation was all wounds were being treated as per physician orders .He stated he expected those that provided wound care to have documented on the treatment administration record. He said he was notified of the confusion on wound care for Resident #3. He said wound care nurses were responsible for following wound care orders . He said failure to sign the treatment administration record revealed the wound care was not being performed. He stated his expectation was for nurses to follow the doctors' orders at all times. Record review of the facility's pressure ulcer/pressure injury (overview) policy, dated July 2018, reflected: Pressure ulcers/injuries will be identified, evaluated, and treated in accordance with generally accepted guidelines. A comprehensive wound and system evaluation is necessary for proper planning and treatment of the wounds. Initial, ongoing, and comprehensive wound evaluations may involve multidisciplinary team members over a period of time.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide food that was palatable, attractive and at a safe and appetizing temperature for 1 of 2 meals (breakfast on 06/12/26) reviewed for palatability and temperature. The facility failed to provide food that was palatable and appetizing temperature for the breakfast meal on 06/12/26. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: Observation on 06/12/26 at 9:50 AM of the 300-hallway revealed residents' breakfast trays were on a mobile cart. Observation on 06/12/26 at 10:10 AM of the 300-hallway revealed the last residents' breakfast tray was passed to them in their room. Observation and interview on 06/12/26 at 10:11 AM with Resident #4, revealed he was in his room lying in his bed eating his breakfast. Resident #4 said his breakfast meal was cold today but he was so hungry he did not ask anyone to heat it up for him. Observation and interview on 06/12/26 at 10:15 AM with Resident #5, revealed he was in his room lying in his bed eating his breakfast. Resident #5 said his breakfast meal was cold today but he was hungry so he did not want anyone to heat it up for him because it would take too long. Interview on 06/12/26 at 1:54 PM with the DM, she said she had not received any cold food complaints recently. The DM said if a resident said the food was cold, the staff can heat the food up or go back to the kitchen to request a new plate that was warm. The DM said she expected the food to be warm when a resident received it. The DM said the purpose of the food being warm when a resident received it was because the taste of it changed. The DM said the kitchen was responsible for serving the food at a warm temperature. The DM said if food was not served to residents warm, they might get upset. Review of the facility's policy, revised 02/06/24, and titled Hot and Cold Food Temperatures reflected: All hot food items must be served to the resident at a palatable temperature.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #2 observed for infection control.The facility failed to ensure LVN A performed hand hygiene and changed gloves during wound care for Resident #2.This failure could affect the residents by placing them at risk for worsening conditions and cross-contamination Findings included:Record review of Resident #2's Comprehensive MDS Assessment, dated 05/05/26, reflected Resident#3 was a [AGE] year-old male who initially admitted to facility on 11/03/21 and readmitted [DATE]. His diagnoses included traumatic brain injury (a disruption in normal brain function caused by a sudden bump, blow, jolt, or penetrating object to the head). The residents' BIMS score was not documented as resident is rarely/never understood. His MDS assessment indicated he was at risk of developing ulcer/ injuries.Record review of Resident #2's order summary report, dated 06/12/26, reflected the following: - Left Buttock Cleanse Wound with normal saline, pat dry, triad past e to peri wound, Gentamicin, Santyl, calcium alginate. cover with dry dressing. ([START 06/12/26 13:55] [Sic] On Day Shift [Time: Shift 1]) AND ([START 06/12/26 13:55] [Sic] As needed anytime)''.Observation on 06/12/26 at 03:27PM with LVN A, providing Resident #2 with wound care revealed, he disinfected the table and left it to dry. He removed gloves, washed hands, and put the supplies together. He washed hands and put on Personal Protective Equipment (PPE). He wheeled the table to Resident #2's bedside. He then washed his hands, put on gloves, and removed the old dressing on Resident #2's sacrum. He did not change gloves and perform hand hygiene. He cleansed the wound with wound cleanser, removed his gloves, washed his hands, put on new gloves, and applied calcium alginate and dry dressing dated 6/12/26.Interview with LVN A on 06/12/26 at 04:17 PM, revealed he was supposed to remove gloves after removing the old dressing and perform hand hygiene. He stated he forgot to change gloves and perform hand hygiene. He stated failure to perform hand hygiene and change of gloves would cause cross contamination and spread of infection. He stated he had done training on infection control and handwashing.Interview on 06/12/26 at 06:07 PM, the DON revealed her expectation was LVN A was supposed to change gloves from dirty to clean and wash hands. She stated failure to change gloves and perform hand hygiene could risk infection and wound getting worse. She stated she had done training with staff on infection control and hand washing during wound care.Record review of the facility Hand Hygiene for Staff and Residents policy, dated July 2024, reflected, .The purpose of this procedure is to reduce the spread of infection with proper hand hygiene '1.Hand hygiene is done:After: A. contact with soiled or contaminated articles, such as articles that are contaminated with body fluids.B. Resident contact.