| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/24/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Accel at Willow Bend | 2620 Communications Parkway<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427<br><br>Based on observation, interview and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 5 residents (Residents #18, #25 and #323) reviewed for resident rights.<br><br>1. The facility failed to ensure Resident #323's call light was within reach.<br><br>2. The facility failed to ensure Resident #25's call light was within reach.<br><br>3. The facility failed to ensure Resident #18's call light was within reach.<br><br>These failures could put residents at risk of not being able to call for assistance, have their needs met, and increases their risk for falls.<br><br>Findings include:<br><br>1. Record review of Resident #323's Quarterly MDS, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #323 had a BIMS score of 12, which indicated moderately impaired cognition.<br><br>Record review of Resident #323 face sheet, dated 07/22/2024, reflected diagnoses which included chronic kidney disease (kidney damage that interferes with blood filtering), peripheral vascular disease hydrocephalus (cerebral fluid in brain), muscle weakness, unsteadiness on feet, keratoconus (condition that thins and distorts the cornea leading to vision loss) and hearing loss.<br><br>Record review of Resident #323 care plan, dated reviewed 07/08/2024, reflected the resident was at risk for falls and interventions were to keep the call light and most frequently used personal items within reach and to remind the resident to call when needing assistance.<br><br>Observation on 07/22/24 at 8:15 AM of Resident #323 revealed he was sitting up in bed with a pillow underneath each arm bent at about a 45-degree angle, both of his hands were resting on top of the pillows and were contracted. Resident #323's call light and bed remote were not within reach and were wrapped around the bottom of the left bed rail. Observation revealed Resident #323 was not able to reach any items on his nightstand which were behind the head of his bed when he was sitting up which included his hearing aids and water.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/24/2024 |
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| NAME OF PROVIDER OR SUPPLIER Accel at Willow Bend | | STREET ADDRESS, CITY, STATE, ZIP CODE 2620 Communications Parkway Plano, TX 75093 | |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 07/22/24 at 08:15 AM with Resident #323 revealed he had been at the facility for several months and had trouble reaching items on the nightstand if he were in a seated upright position, his hands were contracted, and his left arm was partially paralyzed so he was not able to reach around or through the bed rail to reach either the bed remote or call light. Resident #323 stated quite often he was not able to reach the remote for the bed and the call light and did not know why it became tangled often and was not able to get out of bed without assistance. Resident #323 stated he felt frustrated when he could not reach the call light. Resident #323 stated other times it had happened; staff were not sure why the call light was tangled up.<br><br>Observation and interview on 07/22/24 at 8:33 AM with the Staffing Coordinator revealed she observed Resident #323's call light tangled around the bottom of the left bed rail. The Staffing Coordinator untangled and unwound the call light and the bed remote and placed it next to resident on his bed and stated sometimes the call light got tangled up when the resident was placed upright for meals. The Staffing Coordinator stated the call light should always be within reach of the resident, so they were able to call for assistance.<br><br>2. Record review of Resident #25's face sheet, dated 07/22/2024, reflected he was an [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #25 had diagnoses which included hypertension (high blood pressure), hyperlipidemia (high level of fats in blood), and pain.<br><br>Record review of Resident #25's Comprehensive MDS, dated [DATE], reflected he had diagnoses which included dementia (loss of cognition), stroke (disruption of blood supply to brain), septicemia (blood poisoning), depression (persistent feelings of sadness and low energy), and osteomyelitis (inflammation in the bone).<br><br>Record review of Resident #25's care plan reflected he was at risk for falls and was to have his call light and most frequently used personal items within reach and be reminded to use the call light when in need of assistance, dated 06/29/2024.<br><br>Observation and interview on 07/22/2024 at 8:40 AM of Resident #25 revealed he was lying in bed in a slightly upright position with his call light not within reach, it was hanging from the bottom of the right bed rail. Resident #25 stated he did not know where his call light was and could not reach it.<br><br>Interview on 07/22/2024 at 8:51 AM with LVN O revealed he had worked at the facility for almost a month and Resident #25's call light should always be placed near him. LVN O stated the call light was important to have within reach so he could ask for help if needed and he placed the call light in the resident's lap. LVN O stated that he was not sure why Resident #323 call light would be wrapped around the bed rail out of reach.<br><br>3. Record review of Resident #18's face sheet, dated 07/22/2024, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #18's had diagnoses which included senile degeneration of brain (loss of cognition), pain and neuromuscular dysfunction of bladder (lack of bladder control).<br><br>Record review of Resident #18's Comprehensive MDS, dated [DATE], reflected she had a BIMS score of 3, which indicated severely impaired cognition.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #18's care plan reflected she had a terminal diagnosis and was on hospice services through Hospice Q with an onset date of 11/09/2023 and reviewed date of 07/16/2024. Review reflected she was at risk for falls and was to have her call light and most frequently used items within reach with an onset date of 11/09/2023 and reviewed date of 07/16/2024.<br><br>Observation on 07/22/24 at 9:19 AM of Resident #18 revealed she was lying flat on her bed wearing pants with a long sleeve shirt and was non-interviewable. Observation revealed her call light was on floor beside the head of her bed with two wheelchair footrests on top of the cord and plastic bags with trash in them on top.<br><br>Observation and interview on 07/22/2024 at 9:23 AM with CNA P revealed she worked for Hospice Q and provided care to Resident #18. CNA P entered the room to pick up the trash bags. CNA P stated when she came in to provide care for Resident #18 the call light was already on the floor, and she had not gotten around to pick it up yet. CNA P stated she left the room and did not place the call light within the resident's reach because she planned to come back. CNA P stated the call light was important to be within reach of residents, so they were able to call for help.<br><br>Interview on 07/22/24 at 9:27 AM with LVN O revealed he was the charge nurse for the hall of Residents #18, #25, and #323. LVN O stated the call light should be placed next to each resident, within their reach, to ensure they were able to call for help if needed. LVN stated that Resident LVN O stated CNA P should have placed the call light next to the resident even if she planned to come back into the room.<br><br>Interview on 07/23/24 at 11:37 AM with CNA N revealed she worked at the facility for about one year and was the lead CNA for Residents #18, #25 and #323 hall since June of 2024. CNA N stated she noticed a pattern during her morning shifts where some call lights were wrapped around the bed rails or were out of reach of residents. CNA N stated that there had been discussion in morning meetings about the concern. CNA N stated that management are now rounding in the mornings and was not sure when that started. CNA N stated rounds were conducted by CNA's and nurses upon the start of their shifts, they checked on the residents and ensured call lights were in reach. CNA N stated the call light should always be within reach either in the resident lap or pinned to their bed next to their hand because that's how they knew they could call for assistance. CNA N stated it was concerning that Resident's #18, #25 and #323 did not have their call lights within reach and Resident #18 and that all staff are responsible for ensuring a resident's call light is within reach. CNA N stated that CNA's were expected to ensure the resident had their call light within reach before they left the room.<br><br>Interview on 07/23/24 at 3:44 PM with the DON revealed her expectation was the call light should always be within reach, not over the side of the bedrail outside of reach, on the floor, or wrapped around a bedrail, so a resident was able to get to it because it was a resident's only way of communication. The DON stated she expected resident call lights to be placed within reach of a every resident anytime a staff member left the room, even if they intended to come back shortly.<br><br>Record review of facility's call light policy titled Call Lights Answering dated effective January 12, 2018, and Reviewed January 19, 2023, reflected The staff will provide an environment that helps meet the resident's needs by answering call lights appropriately . Procedure .7. When leaving the room, be sure the call light is placed within the resident's reach. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427<br><br>Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for one of five (Resident #50) reviewed for comprehensive care plans.<br><br>The facility failed to ensure Resident #50's care plan was person centered and comprehensive and did not address the resident's resistance to care and resistance to eating and drinking.<br><br>This failure could place residents at risk of not having individual needs met, not to receive needed services, and negatively impact their psychosocial health and wellbeing.<br><br>Findings included:<br><br>Record review of Resident #50's Comprehensive MDS, dated [DATE], reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included hypertension (high blood pressure), hyperlipidemia (high level of fats in blood), Alzheimer's disease (loss of cognition), anxiety disorder (feelings of anxiety or panic), and cataracts (clouding of eye lens). Resident #50 had a BIMS score of 0, which indicated severely impaired cognition.<br><br>Record review of Resident #50's care plan reflected there was a care area problem of wandering due to the resident being a new admission, highly confused and demented with interventions which included assessment of fall risk, determine pattern of wandering, keep a picture at the nurses station, and to make sure staff were aware of elopement risk with an onset date of 07/03/0024 and reviewed on 07/19/2024. There was a care plan area problem of altered nutritional status-the resident had missing teeth and interventions included to provide a snack between meals as preferred, provide favorite foods and beverages, and monitor intake of meals. Review of the care plan revealed there were no problem areas that showed Resident #50 refused meals, resisted being fed by staff, resisted care by staff or was combative.<br><br>Observation on 07/22/24 at 9:26 AM of Resident #50 revealed she was lying in bed asleep with her call light within reach.<br><br>Interview on 07/22/24 at 11:34 AM with the Resident Representative (RR) for Resident #50's representative revealed when she was first admitted to the facility things were rocky, staff were waking her up in a way that startled the resident and after she spoke with the DON about her concerns it seemed to be better. RR stated that Resident #50 does not know how to eat by herself and she asked staff multiple times to place some food on her lip so she tasted it first and if she refused to eat then she should be provided an Ensure. RR stated that she buys and keeps the Ensures in the resident's room but when she comes to visit it seemed as if they were not used. RR stated that she felt like she had to reeducate staff often, it's like one shift person is not communicating to the other. RR stated she was not sure if the Ensure and strategy she asked staff to take when feeding Resident #50 were care planned.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #50's care plan reflected no care area or problems related to resisting care or meals or the RR preference to provide the resident with an Ensure if the resident did not eat a meal.<br><br>Observation on 07/23/24 at 08:55 AM of Resident #50 revealed she was sitting in the wheelchair in her room next to the bed with a breakfast tray in front of her had oatmeal, toast with jam that was about 90% eaten and the oatmeal looked mixed but uneaten. The resident was not responsive to questions and stated she was doing well.<br><br>Observation on 07/23/2024 at 8:57 AM revealed MA L attempted to administer a nutrition boost to Resident #50 she walked into the resident's room with small transparent cup about a 1/4 full of a pink liquid solution. MA L told resident Here, take your Ensure- it is good for you and Resident #50 shook her head, said no, and pushed the hand away of MA L when she tried to place the cup on the resident's lips. MA L attempted to lift the cup to the resident's mouth two other times and the resident pushed it back and frowned and shook her head. MA L repeated herself and stated here, take your Ensure, it is good for you and Resident #50 said is it good for me? MA said Yes, it is. Try it. and Resident #50 shook her head and said I don't think so. MA L told Resident #50 the drink was good for her and to try it and handed it to resident who took the cup and took a large drink but did not finish about a 1/4 of the solution. MA L prompted Resident #50 to drink the rest of the solution and the resident refused then MA L left the room.<br><br>Interview on 07/23/24 at 9:00 AM with MA L revealed she started working at the facility about 5 months ago and was familiar with Resident #50. MA L stated Resident #50 was commonly confused in the mornings or any time after she woke up from sleeping. MA L stated Resident #50 commonly resisted taking medication. MA L stated when Resident #50 refused her medication then MA L tried a couple of more times and tried cuing and prompting the resident and if she still did not take her medicine then she would try to persuade a little later and sometimes that helped. MA L stated Resident #50 took a lot of cuing and prompting to eat and the resident became very resistant if you tried to feed her and gave her an Ensure if she did not eat all her food. MA L stated she attempted to have Resident #50 take the nutritional boost supplement but she would not drink all of it.<br><br>Interview on 07/23/24 at 11:00 AM with the Wellness Director revealed she was familiar with Resident #50 and she didn't stay still all the time and would like to care plan other independent activities such as one on one's and aroma therapy but had not had the opportunity to do so. The Wellness Director stated she did not create care plans, she provided input during a resident's quarterly and annual reviews.<br><br>Interview on 07/23/24 at 11:28 AM with LVN O revealed he was familiar with Resident #50 and was the charge nurse for her hall. LVN O stated Resident #50 was new to the facility, had dementia, was on hospice services, and her RR visited often. LVN O stated Resident #50 enjoyed drinking Ensure and sometimes she resisted care or taking medications. LVN O stated he knew to take his time when he administered medications or care for Resident #50.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 07/23/24 at 11:37 AM with CNA N revealed she had worked at the facility for about one year and was the lead CNA for Resident #50's hall since June 2024. CNA N stated she was familiar with Resident #50 and she was very combative when provided with care, did not like to eat, and needed to be a 3 person assist due to the behaviors during care. CNA N stated Resident #50 would kick and scratch and refused to be changed. CNA N stated she tried for 10-15 minutes yesterday to get the resident to eat some oatmeal but all she ate was toast with grape jelly. CNA N stated she saw the resident eat hush puppies and seasoned fish the RR brought in for the resident and offered Resident#50 grapes or bananas or gave her an Ensure. CNA N stated she noticed Resident #50 enjoyed the strawberry flavor more than chocolate. CNA N stated she was not sure if Resident #50's behaviors were care planned.<br><br>Interview on 07/23/24 at 1:07 PM with the Dietician revealed she was not very familiar with Resident #50 and she last saw her on 07/08/2024. The Dietician stated Resident #50's refusal of the nutrition boost solution should have been documented and her preference for Ensure, which included preferred flavor, should have been care planned. The Dietician stated she was not aware the RR had Ensure in the Resident's refrigerator and asked staff to give Resident #50 an ensure if she did not eat much or refused her meal.<br><br>Interview on 07/23/2024 at 4:05 PM with LVN U revealed she was familiar with Resident #50 and worked at the facility since November of 2023. LVN U stated Resident #50 had dementia and resisted taking medications and care. LVN U stated Resident #50 had scratched her when resisting care. LVN U stated sometimes the RR was able to get Resident #50 to cooperate with staff and sometimes the RR needed help from staff.<br><br>Interview on 07/24/24 at 2:42 PM with the MDS Nurse revealed she had a care plan meeting on 07/01/2024 with Resident #50's RR, the Rehabilitation Manager, and the Social Services Director was present. The MDS Nurse stated typically nursing was included in the care plan meeting and did not remember if nursing was in the meeting. The MDS Nurse stated she was responsible for creating the care plans and she depended on the rest of the interdisciplinary team to inform her of changes that required care planning. The MDS Nurse stated she remembered they discussed Resident #50 had wandering behaviors and did not like to eat and did not remember anyone mentioning other behaviors. The MDS Nurse stated she thought she heard Resident #50 was resistant to care and was not sure when or how she knew of it and did not know if it was care planned or not. The MDS Nurse reviewed Resident #50's care plan and stated the only behaviors that were care planned were the wandering behaviors she had when she was living with the RR. The MDS Nurse stated the care plan notes she had the care area or problem of anti-anxiety based not having a prescription for lorazepam 1 mg as needed for anxiety and did not know what she had anxiety about. The MDS Nurse stated the care plan was comprehensive because the resident had not been given any doses of lorazepam and did not require personalized interventions for a medication she had not yet received. The MDS Nurse stated she did not care plan any interventions for Resident #50 resisting care or specific food preferences because she was not aware of them. She stated that care plans were important because they show what a residents needs and problem areas were.<br><br>Interview on 07/24/24 at 3:20 PM with the DON revealed her expectation was care plans should be personalized to the resident and if a resident had a diagnosis or problem with anxiety there should be personalized interventions that showed what situations the anxiety was displayed or what prevented anxiety for that resident. The DON stated she would expect the MDS nurse to speak with nursing to obtain their input of what they were seeing if they were not present in a care plan meeting.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's care plan policy titled Comprehensive Care Plans, dated effective 01/12/2018 and reviewed 04/17/2023, reflected:<br><br>Policy: It is the policy of this facility to develop and implementation a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .<br><br>Record review of the facility's psychotropic drug use policy titled Psychotropic Drugs-Use, dated effective 02/12/2020 and revised 07/27/2022 reflected:<br><br>.5. Address the documented behaviors in the patient/resident care plan, including:<br><br>A. Problem (s)<br><br>B. Patient/Resident specific goals<br><br>C. Outcomes<br><br>D. Interventions |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560<br><br>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 and oral hygiene for one of six residents (Resident #57) reviewed for ADL care.<br><br>The facility failed to ensure Resident #57 had her fingernails trimmed.<br><br>This failure could place residents at risk for loss of dignity, risk for infections and a decreased quality of life.<br><br>Findings include:<br><br>Record review of Resident #57's Quarterly MDS assessment, dated 07/10/2024, reflected Resident #57 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hypertension ( high blood pressure) , bipolar disorder (mental illness associated with episodes of mood swings from depressive lows to manic highs), viral pneumonia (infection of the lungs caused by a virus) , chronic pulmonary embolism ( a blockage of pulmonary arteries that happens when a blood clot does not dissolve over time despite treatment) , and depression (a low mood or loss of interest in activities, causing an impairment in daily life). Resident #57 had a BIMS score of 14, which indicated Resident #57's cognition was intact. Resident #57 required supervision with personal hygiene.<br><br>Record review of Resident #57's Comprehensive Care Plan, revised 7/14/2024, reflected the following: Care Area: Self Care Deficit. Goal: Bathing: [Resident#57] will assist with bathing and hygiene on a daily basis. Interventions: Encourage [Resident #57] to participate in ADLs and praise accomplishments.<br><br>An observation and interview on 07/22/24 at 10:33 AM revealed Resident #57 was lying down in the bed in her room. The nails on both hands were approximately 0.5 centimeter in length extending from the tip of his fingers and some of them were chipped. Resident #57 stated she did not like her long nails; she wanted them short and was unable to cut them by herself. She stated she did not ask the staff to trim her nails because she did not want to be in trouble .<br><br>In an interview on 07/22/24 at 01:33 PM with CNA B, he stated both CNAs and LVNs were responsible for nail care during shower days and as needed. He stated if a resident had diabetes, only nurses were allowed to provide nailcare. He stated the risk for not performing nailcare was increased risk of infection.<br><br>In an interview on 07/22/24 at 01:53 PM with RN C revealed both CNAs and RN/LVN could provide nailcare to the resident. She stated Resident #57 had very long nails and she did not remember if she had any refusals. She stated she would ask if podiatry would want to cut her fingernails. She stated the risk for not performing nailcare was increased risk of infection and skin break down. She stated she would ask the incoming nurse for 2-10 shift on 7/22/24 to trim Resident #57's fingernail .<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 07/22/24 at 03:06 PM with the DON revealed her expectation was nail care should be provided every shower day and as needed. She stated both CNAs and Nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare if resident had diagnosis of diabetes. She also stated the Podiatrist was only called for toenails on as needed basis. She stated as the DON she rounded residents frequently and checked if ADLs were performed. The DON stated residents who had dirty fingernails could be an infection control issue.<br><br>In an interview on 07/23/24 at 10:07 AM with the ADON E revealed her expectation was nail care should be provided every shower day and as needed. She stated both CNAs and Nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare if resident had a diagnosis of diabetes. She also stated Podiatry only did toenails, and they were not called for fingernails. She stated as the ADON she conducted spot checks and daily rounds for monitoring. The ADON stated residents who had long, chipped fingernails could be an infection control issue.<br><br>In an interview on 07/24/24 at 10:09 AM with LVN D revealed CNAs were responsible for cleaning and clipping fingernails on shower days for all residents, except resident with a diagnosis of diabetes. She stated CNAs were to notify the Nurse should resident refused nailcare. She stated she had taken care of Resident #57 several times in the past and had not heard of any refusals with ADL care. She stated she offered nailcare to Resident #57 and clipped her nails on 7/22/24 after RN C notified her. She stated resident with long, chipped, dirty fingernails could be at high risk of infection.<br><br>Record review of the facility's policy titled Bathing, revised February 12, 2020, reflected, . Perform hand hygiene and perform nail care |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Accel at Willow Bend | | STREET ADDRESS, CITY, STATE, ZIP CODE 2620 Communications Parkway Plano, TX 75093 | |

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918

Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for three of four residents (Resident #5, Resident #44 and Resident #176) reviewed for catheter and incontinence care.

1. The facility failed to ensure the Staffing Coordinator and CNA F maintained the foley catheter drainage bag below Resident #5's bladder during a mechanical lift transfer.

2. The facility failed to ensure CNA G provided appropriate and timely incontinence care for Resident #44 on 07/23/24.

3. The facility failed to ensure the Therapist did not place the urine catheter bag on the floor during the transfer of Resident #176 from his bed to the wheelchair.

These failures could place residents at risk for not receiving care appropriate to address their incontinence and could increase the risk of urinary tract infections.

Findings included:

1. Record review of Resident #5's quarterly MDS assessment, dated 06/06/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS of 3, which indicted he was severely cognitively impaired. Resident #5 required substantial/maximum assist with toileting and transfers, had an indwelling catheter and was always incontinent of bowel. Resident #5 had diagnoses which included neurogenic bladder (loss of bladder control due to brain, spinal cord, or nerve problems) and hemiplegia (paralysis that affects one side of the body).

Record review of Resident #5's care plan, with an onset date of 06/16/24, reflected, Suprapubic catheter (catheter that in inserted through the abdomen into the bladder) .Goal-Resident will be free of complications of indwelling catheter over the next 90 days .Interventions .Keep catheter tubing placed below level of bladder .use leg strap to avoid pulling catheter

Record review of Resident #5's Consolidated order, dated 07/24/24, reflected .Foley catheter 16 FR every shift to continuous gravity drainage and catheter care .with a start date of 05/30/24.

Observation on 07/22/24/24 at 10:45 a.m. revealed the Staffing Coordinator and CNA F entered Resident #5's room to get the resident up for the day. The Staffing Coordinator placed the catheter drainage bag, which had approximately 200 cc of urine, on the bed while preparing to place the mechanical lift sling under the resident. Both staff positioned the resident on the sling. The Staffing Coordinator picked up the catheter drainage bag and placed it top of Resident #5's abdomen. The staff raised the resident from the bed with the catheter drainage bag remained on the resident's abdomen, above the resident's bladder. Urine was observed flowing back toward the resident's bladder. The staff then positioned him over his wheelchair and lowered him into his chair and then placed the catheter bag onto the side of his wheelchair.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Accel at Willow Bend | | STREET ADDRESS, CITY, STATE, ZIP CODE 2620 Communications Parkway Plano, TX 75093 | |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview with the Staffing Coordinator on 07/22/24 at 10:50 a.m., she stated she was trained to always keep the catheter drainage bag below the bladder. She stated she was just not thinking. She stated having it above the bladder could possibility cause the urine to run backwards, which could cause an infection. She stated placing the bag on the bed could cause a risk of cross contamination. She stated she was the one who performed the skills checks on the CNA staff and could not recall if it included how to handle the catheter drainage bag during a transfer but stated it would always need to be below the bladder.<br><br>In an interview with CNA F on 07/22/24 at 10:55 a.m., she stated they should not have placed the catheter bag in Resident #5's lap. She stated she should have said something when the Staffing Coordinator placed it on Resident #5's lap. when the resident held out his hand for the bag, they just handed it to him without thinking. She stated she knew the catheter bag and tubing were to be kept below the bladder to prevent urine from backing up and might cause an infection.<br><br>Record review of the Staffing Coordinator skill checks, dated 04/16/24, reflected she was competent in Indwelling catheter care and hand hygiene.<br><br>2. Record review of Resident #44's significant change in status MDS assessment, dated 05/25/24, reflected a [AGE] year-old male with an admitted [DATE] and readmitted [DATE]. Resident #44 was unable to participate in the interview for cognition and was assessed by the staff to be severely impaired. He was dependent for ADL care and was always incontinent of urine and bowel. His active diagnoses included respiratory failure with hypoxia (not enough oxygen in the blood). In Section O-Special Treatments, Procedures, and Programs it reflected he required tracheostomy care and oxygen therapy during the 14 days look back period.<br><br>Record review of Resident #44's care plan, reviewed on 06/12/24, reflected, .At risk for problems with elimination .Requires extensive assistance for toileting .Skin Breakdown: at risk for/actual related to history of rash/dermatitis .Interventions. Check resident every two hours and assist with toileting as needed .Provide peri care after each incontinent episode .Keep skin clean, dry, and free of irritants<br><br>An observation on 07/23/24 at 03:09 p.m. revealed CNA F and CNA H entered Resident #44's room to provide incontinence care. Both staff performed hand hygiene and put on gloves. LVN J entered the room and placed the G-tube pump on hold. CNA F opened the resident's brief to reveal another brief wadded up into a ball and placed over the resident's penis. CNA F stated this was not normal and no resident should be double briefed. CNA F removed the wadded-up brief, which revealed the resident's scrotum was red. CNA F provided peri care and with assistance from CNA H turned the resident over on his side to reveal he had saturated through the brief and the draw sheet down to the bed. Resident #44's buttocks was red with creases noted in skin, but no skin breakdown. CNA F provided peri-care and applied barrier cream to the resident's buttocks.<br><br>In an interview with CNA F on 07/23/24 at 03:10 p.m., she stated she worked the 6-2 p.m. shift today as well but had not assisted with his care. She stated CNA G was assigned to Resident #44 and asked her once to help with his care, but she stated she was giving a shower and was not sure who assisted her. She stated resident #44 was a heavy wetter so they had to check him frequently.<br><br>In an interview with the 6-2 p.m. Charge nurse, LVN I on 07/23/24 at 03:35 p.m., she stated CNA G had not requested assistance from her with incontinent care for Resident #44 on her shift.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/24/2024 |
|---|---|---|---|
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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview with CNA G on 07/23/24 at 03:40 p.m., she stated she was assigned to Resident #44 today (07/23/24) and provided incontinence care to him around noon. She stated she had given him a bed bath and shaved him. She stated, I did it and I know it was wrong, she stated she placed the wadded-up the brief on him because she did not want him to be soaked when she came back for her final check, but stated she forgot to go back and check him and remove the brief before her shift and ended at 02:00 p.m. She stated she knew she was not supposed to do what she did. She stated she provided the care to him by herself because there was no one available when she needed the assistance. She stated she knew better and should not have done what she had done.<br><br>Record review of CNA G's skill checks, dated 07/02/24, reflected she was competent in perineal care.<br><br>3. Record review of Resident #176's Comprehensive MDS assessment, dated 07/22/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS of 13, which indicted he was cognitively intact. Resident #176 required substantial/maximum assist with toileting and transfers, had an indwelling catheter. Resident #176 had diagnoses included metabolic encephalopathy (a neurological disorder that occurs when a chemical imbalance in the blood caused by an illness or organ dysfunction affects the brain) and kidney failure.<br><br>Record review of Resident #176's care plan, with an onset date of 07/20/24, reflected, Urinary catheter (catheter that in inserted into the bladder through the urethra to allow urine to drain from the bladder for collection) .Goal-Resident will be free of complications of indwelling catheter over the next 90 days<br><br>Observation on 07/23/24/24 at 11:16 AM revealed the Therapist and CNA K entered Resident #176's room to provide incontinent care and get the resident up for therapy. The Therapist assisted CNA K to provide incontinent care to Resident #176. After completion of the continent care the Therapist proceeded to transfer Resident #176 from bed to wheelchair. The Therapist placed the catheter drainage bag, which had approximately 200 cc of urine, on the floor while assisting Resident #176 to sit on the bed. She instructed the resident to sit closer to the edge of the bed, she helped him to do so. While the catheter drainage bag was still on the floor, the Therapist assisted Resident #176 to the standing position using the walker to support Resident #176 in the standing position. The Therapist positioned the resident on the wheelchair. She picked up the catheter drainage bag from the floor and put in the dignity bag and hanged it onto the sides of his wheelchair. The Therapist removed her gloves, washed her hands and Resident #176 in his wheelchair to therapy room.<br><br>In an interview with the Therapist on 07/23/24 at 11:30 AM, she stated she was trained to always keep the catheter drainage bag out of the floor. She stated she just overlooked it. She stated placing the bag on the floor would cause a risk of cross contamination. She stated she was supposed to hang the urine bag on the side of the bed or the side of the wheelchair.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/24/2024 |
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| NAME OF PROVIDER OR SUPPLIER Accel at Willow Bend | | STREET ADDRESS, CITY, STATE, ZIP CODE 2620 Communications Parkway Plano, TX 75093 | |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview with the DON on 07/24/24 at 10:00 a.m., she stated any resident with a foley catheter should always have the bag and tubing below the bladder and should never be placed on the bed or in the resident's lap. She stated placing the bag on the floor would place residents at risk of a urinary tract infection and cross contamination. She stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of a urinary tract infection and cross contamination. She stated all the staff had been trained numerous times on the expectation of performing hand hygiene after completion of care, after removing gloves and before they leave the resident's room. She stated at no time was the staff to ever brief a resident double she stated this placed at resident at risk of skin breakdown and increased risk of urinary tract infections. She stated the expectation was staff were to check and change if needed every 2 hours, or if the resident was a heavy wetter, then it needed to be more frequent. She stated to ensure staff were knowledgeable in the care of indwelling catheter and hand hygiene and peri-care the facility did skills competency checks and she stated she and the ADONs made daily rounds and watched care. She stated she did spot checks on residents to ensure they were receiving timely care.<br><br>Record review of the facility's policy titled, Urinary Catheter Infection Prevention, dated January 2022, reflected, All personnel involved in the handling and maintenance of catheters are periodically trained on the methods and techniques utilizing current recommendations and the facility policies .Whenever handling catheters or urinary drainage systems hands are washed both before and after .Gravity drainage bags are positioned below the level of the patient's bladder .Gravity drainage bags are kept off the floor. If these inadvertently touch the floor, clean the outside of the bag using soap and water or appropriate disinfectant<br><br>Record review of the facility's policy titled, Perineal Care, dated, April 2024, reflected, Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection |

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|---|---|---|---|
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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918

Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care, was provided such care, including tracheostomy care and tracheal suctioning, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for one of one resident (Resident #44) reviewed for tracheostomy care.

The facility failed to ensure LVN I maintained a sterile/clean field for supplies necessary for tracheostomy care.

The facility failed to ensure LVN I kept her dominant (right) hand sterile while providing trach care and tracheal suctioning for Resident #44.

These failures could place residents at risk for respiratory infections.

Findings include:

Record review of Resident #44's significant change in status MDS assessment, dated 05/25/24, reflected a [AGE] year-old male with an admitted [DATE] and readmitted [DATE]. Resident #44 was unable to participate in the interview for cognition and was assessed by the staff to be severely impaired. He was dependent for ADL care and was always incontinent of urine and bowel. His active diagnoses included respiratory failure with hypoxia (not enough oxygen in the blood). In Section O-Special Treatments, Procedures, and Programs it reflected he required tracheostomy care and oxygen therapy during the 14 days look back period.

Record review of Resident #44's Physician consolidated orders, dated 07/24/24, reflected, .Trach Care 2 times per day Bivona size 7. Cleanse outer trach stoma with NS, Pat Dry Apply dressing. Change ties when soiled ., with a start date of 06/13/24.Suction Trach as needed . with a start date of 02/22/24.

Record review of Resident #44's care plan, reviewed on 06/12/24, reflected, .Tracheostomy .Trach Care 2 times per day .Suction trach as needed .Goal .Effective airway will be maintained and monitored over the next 90 days .Interventions .Change dressings and ties every day or when they become soiled .Clean tracheostomy tube, inner cannula per physician's order .Observe stoma for redness, swelling, bleeding and signs of infection

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/24/2024 |
|---|---|---|---|
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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an observation on 07/22/24 at 10:05 a.m. revealed LVN I entered Resident #44's room to change out the oxygen tubing, the suction machine tubing and performed the resident's daily trach care. LVN I connected the oxygen tubing and removed the old tubing from the suction machine and replaced it with new tubing and then opened a package of sterile trach suction kit and attached the suction catheter to the suction machine tubing and placed it in a plastic bag handing on the chest of drawers next to the residents bed. She then placed 2 paper containers on top of the chest of drawers and filled them with normal saline. She then sanitized her hands, put on gloves, and cleaned the bedside table with a germicidal wipe and allowed to dry. She removed her gloves and performed hand hygiene. She then placed a piece of wax paper on top of the bedside table and sat out her supplies which included 4 x 4 gauze (unsterile), trach care kit, extra trach ties. LVN I then washed her hands put on a gown and gloves and removed the old stoma dressing from around the trach. She removed her gloves and washed her hands. She then opened the trach care kit and pulled out the sterile drape and placed it to the side as well as the brush, q tips and neck ties and removed sterile gloves and placed them on the wax paper. She put on the sterile gloves and then reached around and picked up the paper container on top of the chest of drawers containing the normal saline and poured it into the trach care tray, thus contaminating her gloves. LVN I then placed some gauze in the saline and wiped around the stoma site, which caused the resident to cough up phlegm. She then wiped away the phlegm with more gauze and then took the brush, dipped it into saline, cleaned the outside to the trach and then entered the end of trach with the brush, which then caused the resident to cough again. LVN I then reached into the bag with the same gloves used to clean the stoma and wipe away the phlegm and removed the tracheal suctioning catheter and inserted it into the trach and suctioned the resident. She then placed the suctions catheter back into the plastic bag hanging on the chest of drawers. LVN I then opened a package with a stoma dressing and placed the clean stoma dressing around the trach. LVN I then removed her gloves and put on a new pair of utility gloves without performing hand hygiene and replaced the trach ties.<br><br>In an interview with LVN I on 07/22/24 at 10:40 a.m., she stated she used the trach brush when he coughed up the phlegm. She stated she was not aware she should not use the brush on the trach. She stated she knew she messed up with the sterile gloves. She stated she was trained on trach care but she just forgot some of the steps. She stated she knew trach care and suctioning was supposed to be sterile. She stated she should not have placed the tracheal suction tubing in the plastic bag.<br><br>In an interview on 07/24/24 at 11:35 a.m., the DON stated trach care was considered a sterile procedure. She stated when LVN I contaminated her gloves and did not follow the proper steps of trach care she posed the risk of respiratory infections to the resident. She stated all the staff assigned to Resident #44 had been skills checked by their contracted RT just a few months ago.<br><br>In an interview on 07/23/24 at 10:52 a.m., with the facility's RT Consultant, she stated she was contracted with the facility to provide Respiratory evaluations and provided training to the staff on trach care and was available by phone for any questions. She stated they did a class in May with the staff that needed tracheostomy care training. She stated LVN I was in the class. She stated LVN I did not pass the first competency test and had to review the procedure again but did pass the second time. She stated she told the ADON she would need some monitoring until she built up her confidence in her skill level. She stated she was teaching trach care as a clean technique, but stated the staff needed to have all their supplies opened and set up prior to putting on the sterile gloves to prevent the risk of cross contamination and infection. She stated the staff needed to change gloves and perform hand hygiene when going from dirty to clean and had never been taught to place the suction catheter into a plastic bag.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a follow up interview with the DON on 07/24/24 at 10:05 a.m., she stated going forward she was going to be the one ensuring the nurses assigned to specialty care were trained and qualified and she and her ADONs would be doing more frequent skills checks and monitoring of the staff and provided more frequent refresher classes. She stated LVN I had been re-educated and skills checked on 07/22/24.<br><br>Record review of LVN I skills Respiratory competency evaluation reflected she had been skills checked on Tracheal Suctioning and Tracheostomy care on 05/24/24 and again on 06/13/24.<br><br>Record review of the facility's policy, Tracheostomy Care' dated March 2023, reflected, Staff will provide care for residents with a tracheostomy in accordance with standard practice Guidelines<br><br>Record review of the facility's skills check titled, The Nursing Services-Respiratory Competency Evaluation for Tracheostomy care, dated March 2023, reflected .Verify orders for type and size of tracheostomy tube and inner cannula.<br><br>.Gather trach care kit and suctions supplies, ensure emergency supplies are kept at bed side . Wash hands and apply PPE appropriate for risk of contact with secretions .Suction and clear airway if needed .Open and prepare trach care kit .Wash hands and apply gloves .Grasp the flange with dominant hand .Cleanse outer cannula surfaces and skin around the stoma using a circulation motion from stoma site outward .While securing trach tube, remove old tracheostomy tie .replace trach ties ensuring one or two finger widths between neck and tie .Ensure tube is midline and replace dressing under faceplate<br><br>Record review of the facility's skills check titled, Tracheal Suctioning, dated March 2023, reflected, .Test suction machine with thumb applied to tubing .Wash hands and apply PPE appropriate to risk of exposure to secretions .Open sterile water or normal saline. Open sterile catheter and place on sterile filed .Fill basin with about 100 ml of sterile normal saline .then don sterile gloves without contamination .Pick up suction catheter with dominant hand without touching non-sterile surface, pick up connection tubing with non-dominant hand and connect to catheter .Place tip o catheter in sterile basin and suction small amount of solution .Insert catheter gently but quickly through tracheostomy without suctioning .Apply suction during removal of catheter for no more than 10-15 seconds .Allow resident to time between suctioning .dispose of supplies .perform hand hygiene |

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|---|---|---|---|
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>42971<br><br>Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 4 carts (Med Aide cart hall 500) reviewed for pharmacy services.<br><br>The facility failed to ensure LVN S and LVN R, responsible for Med Aide cart hall 500, counted controlled drugs every shift change and signed the narcotic sheet form after the count.<br><br>This failure could place residents at risk of not having the medication available due to possible drug diversion.<br><br>Findings include:<br><br>Record review and observation on 07/22/24 at 8:40 AM of Med Aide Cart halls 500, revealed missing signatures for Off duty and On duty for 07/02/24, 07/03/24, 07/04/24, 07/05/24, 07/06/24, 07/11/24, 07/12/24, 07/15/24, 07/16/24, and 07/18/24 of the narcotic count sheet.<br><br>Interview on 07/24/24 at 03:06 PM, LVN S stated she should have signed the narcotic sheet after counting the narcotics on 07/11/24, 07/12/24, 07/15/24, 07/16/24, and 07/18/24 because it was the proof that she counted with the other nurse . LVN S stated the risk of not signing the narcotic sheets would be a potential for drug diversion. She stated she did not remember why she did not sign the narcotic sheet for all those days .<br><br>Interview on 07/24/24 at 03:45 PM, LVN R stated he should have signed the narcotic sheet before and after counting the narcotics on 07/02/24, 07/03/24, 07/04/24, 07/05/24, and 07/06/24 . LVN D stated, I counted the narcotics but forgot to sign. LVN R stated it was very important to count before he took the keys. He stated he might get busy after he counted with the other nurse and he forgot to go back and sign the count sheet. He stated this failure could potentially cause a drug diversion.<br><br>Interview on 07/24/24 at 10:00 AM, the DON stated she expected nurses to sign the narcotic count sheet at the beginning and at the end of their shift after they completed count with the incoming and off-going nurse. The DON stated if the staff were not signing the narcotic count sheets, she was unable to prove they were counting. The DON stated it was important to ensure a drug diversion did not occur. The DON stated the ADON, and the DON were supposed to check the cart randomly for monitoring . Medication count was done and no drug diversion was noticed.<br><br>Record review of the facility's policy Controlled Medication Storage, dated September 2007, reflected the following: . 6. At each shift change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. The nursing care center may elect to count all controlled medications at shift change |

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|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560<br><br>Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 facility kitchen reviewed for food safety.<br><br>1. The facility failed to discard food stored in the refrigerator that should no longer be consumed.<br><br>2. The facility failed to ensure food item in the walk-in refrigerator had use-by date and labeled .<br><br>3. The facility failed to ensure a bin of hard-boiled eggs in the walk-in refrigerator was appropriately covered .<br><br>These failures could place residents at risk for food-borne illness and food contamination.<br><br>Findings include:<br><br>Observation on [DATE] at 08:13 AM in facility's walk-in refrigerator revealed a half-used container of chopped garlic in water with an expiration date of [DATE].<br><br>Observation on [DATE] at 08:14 AM in facility's walk-in refrigerator revealed a white, cream-like food in one-gallon Ziplock bag that was unlabeled and undated. The zip-lock bag was placed in a medium-size brown corrugated box that had packaged cheese blocks.<br><br>Observation on [DATE] at 08:15 AM in facility's walk-in refrigerator revealed hard-boiled eggs in a large plastic bin that were not securely covered and left exposed.<br><br>In an interview on [DATE] at 12:53 PM with [NAME] A revealed everyone in the kitchen was responsible for covering, dating, and labeling food items, she stated she was serving breakfast on the morning of [DATE] and forgot to securely close the lid of the hard-boiled egg bin after using the eggs for breakfast. She also stated she did not identify the white unlabeled, undated items in the facility refrigerator since she did not place it there. She stated the cooks were usually responsible for checking expiry dates on food items before using them and the expired food items should be promptly thrown away after notifying the dietary manager. She stated they were in serviced in the past about labeling each food item if it was out of its original container and writing the use-by date on it. She stated the risk of using expired food products for cooking or not appropriately dating, labeling, covering food items could lead to residents being sick and possible food contamination.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on [DATE] at 12:58 PM with Dietary Manager revealed her expectation was all kitchen staff were responsible for dating, labeling, and covering food items. She stated the unlabeled and undated food item in the refrigerator was left over yogurt that was poured into the zip-lock bag and should have been labeled with yogurt as well as had a use-by date on it. She also stated it should not be placed in the cheese box and would re-educate the kitchen staff on appropriate dating and labeling of food items. She stated cooks were responsible for overseeing expired food items in the kitchen and needed to follow First-In-First-Out protocol for all food items. She stated there were low in staffing on the morning of [DATE] and the cook who was serving breakfast may have left the egg bin exposed and forgot to close the lid tightly. She stated as the Dietary Manager, she made rounds in the kitchen every morning to ensure all foods were appropriately date, labeled and covered each day; however, was unable to do so on [DATE] since she was busy with helping for Breakfast service. She stated the risk to residents for using expired food products or not dating, labeling, covering food was lapses in infection control in the kitchen and food contamination .<br><br>In an interview on [DATE] at 1:12 PM with the Dietitian revealed her expectation was all food items in the kitchen were labeled, dated with a use-by date, and covered appropriately by all kitchen staff. She stated her expectation was all foods should be checked for expiry dates and expired foods should be promptly thrown away and the Dietary Manager should be notified. She also stated unlabeled, undated, food items could not be identified and needed to be thrown away. She stated there was a risk for residents to get sick with possible food borne illness/infection if expired, undated, unlabeled, uncovered food items were used in the facility's only kitchen .<br><br>Record review of the facility's policy titled Food Storage, revised February 6, 2024, reflected.2. Refrigerator: . All foods are covered, labeled, and dated .Facility policy for Expired food items was not available for review<br><br>Record review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food , d+[DATE].11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918<br><br>Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 6 of 16 residents (Resident #7, Resident #18, Resident #13, Resident#16, Resident#176, and Resident#5) reviewed for infection control.<br><br>1. The facility failed to ensure MA L disinfected the blood pressure cuff in between blood pressure checks for Residents #7 and #18.<br><br>2. The facility failed to ensure MA M disinfected the blood pressure cuff in between blood pressure checks for Residents #13 and #16.<br><br>3. The facility failed to ensure CNA K performed hand hygiene while providing incontinence care to Resident # 176.<br><br>4. The facility failed to ensure the Staffing Coordinator performed hand hygiene after completion of a mechanical lift transfer for Resident #5 and prevented cross contamination when the catheter drainage bag was placed on the resident's bed<br><br>These failures could place residents at risk of cross contamination which could result in infections or illness.<br><br>Findings include:<br><br>1.Record review of Resident #7's Quarterly MDS assessment, dated 04/26/24, reflected Resident #7 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #7 had diagnoses which included type 2 diabetes mellitus, elevated blood pressure, and stroke (damage to the brain from interruption of its blood supply). Resident #7 had a BIMS of 12, which indicated Resident #7's cognition was moderately impaired.<br><br>Record review of Resident #18's Quarterly MDS assessment, dated 02/12/24, reflected Resident #18 was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included senile degeneration of brain (cognitive decline in older people, especially memory loss), and neuromuscular dysfunction of the bladder (a urinary tract condition that occurs when the nerves and muscles of the urinary system don't work together properly.) Resident #18 had a BIMS of 99, which indicated Resident #18 was unable to complete the interview (impaired cognition.)<br><br>Observation on 07/22/24 at 7:25 AM revealed MA L performed morning medication pass, during which time she checked the blood pressure on Resident #7. MA L did not sanitize the blood pressure cuff before and after using it on Resident #7, continued to the next resident without sanitizing the blood pressure cuff. MA L then checked Resident #18's blood pressure. MA L did not sanitize the blood pressure cuff before using it on Resident #18.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 07/22/24 at 7:50 AM, MA L stated reusable equipment, like blood pressure cuffs, should be sanitized before and after use on each resident in order to keep germs from spreading. She stated she forgot to sanitize the blood pressure cuff between residents use because she was nervous.<br><br>2. Record review of Resident #13's Quarterly MDS assessment, dated 07/09/24, reflected Resident #13 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #13 had diagnoses which included elevated blood pressure, and cerebrovascular accident (damage to the brain from interruption of its blood supply). Resident #13 had a BIMS of 00, which indicated Resident #13's cognition was severely impaired.<br><br>Record review of Resident #16's Comprehensive MDS assessment, dated 06/19/24, reflected Resident #16 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included fracture of left lower leg and elevated blood pressure. Resident #16 had a BIMS of 15 which indicated Resident #16's cognition was unable intact.<br><br>Observation on 07/22/24 at 8:10 AM revealed MA M performed morning medication pass, during which time she checked the blood pressure on Resident #13. MA M did not sanitize the blood pressure cuff before and after use on Resident #13 and continued to the next resident without sanitizing the blood pressure cuff. MA M then checked Resident #16's blood pressure. MA M did not sanitize the blood pressure cuff before using it on Resident #16.<br><br>Interview on 07/22/24 at 8:15 AM, MA M stated reusable blood pressure cuffs, should be sanitized before and after use on each resident. She stated the risk of not sanitizing the blood pressure cuff between use would be cross contamination and spread of infections. She stated she forgot to sanitize the blood pressure cuff between use on Resident #13 and Resident #16.<br><br>3. Record review of Resident #176's Comprehensive MDS assessment, dated 07/22/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS of 13 which indicted he was cognitively intact, required substantial/maximum assist with toileting and transfers, had an indwelling catheter. Resident #176 had diagnoses which included metabolic encephalopathy (a neurological disorder that occurs when a chemical imbalance in the blood caused by an illness or organ dysfunction affects the brain) and kidney failure.<br><br>Record review of Resident #176's care plan, with an onset date of 07/20/24, reflected Urinary catheter (catheter that in inserted into the bladder through the urethra to allow urine to drain from the bladder for collection) .Goal-Resident will be free of complications of indwelling catheter over the next 90 days .Problem: at risk for problems with elimination. Goal: Decrease in number of incontinent episodes<br><br>Observation on 07/23/24 at 11:01 AM revealed CNA K and Therapist entered Resident #176's room to provide incontinence care. Both staff washed hands and donned gloves and gowns CNA K unfastened the brief and cleaned the front pubic area using incontinent wipes. The resident was assisted onto his side. CNA K discarded the dirty gloves, without hand hygiene she donned clean gloves. The Therapist held the resident and CNA K cleaned the resident's buttocks area using several wipes which revealed a smear of bowel movement. CNA K discarded the dirty gloves, without hand hygiene, she donned clean gloves, she placed a clean brief under the resident. Both staff repositioned the resident back on his back. CNA K gathered the dirty clothes and trash, removed her gloves and washed her hands.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 07/23/24 at 11:35 AM, CNA K stated she was to wash hands before and after care. CNA K also stated she was supposed to complete hand hygiene after removing the dirty gloves. CNA K stated she did not complete hand hygiene between change of gloves because she was rushing. CNA K stated she was supposed to complete hand hygiene to prevent the spread of infection.<br><br>4. Record review of Resident #5's quarterly MDS assessment, dated 06/06/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS of 3, which indicted he was severely cognitively impaired, required substantial/maximum assist with toileting and transfers, had an indwelling catheter and always incontinent of bowel. Resident #5 had diagnoses which included neurogenic bladder (loss of bladder control due to brain, spinal cord, or nerve problems) and hemiplegia (paralysis that affects one side of the body).<br><br>Record review of Resident #5's care plan, with an onset date of 06/16/24, reflected Suprapubic catheter (catheter that in inserted through the abdomen into the bladder) .Goal-Resident will be free of complications of indwelling catheter over the next 90 days .Interventions .Keep catheter tubing placed below level of bladder .use leg strap to avoid pulling catheter<br><br>Observation on 07/22/24/24 at 10:45 a.m. revealed the Staffing Coordinator and CNA F entered Resident #5's room to get the resident up for the day. The Staffing Coordinator placed the catheter drainage bag, which had approximately 200 cc of urine, on the bed while preparing to place the mechanical lift sling under the resident. Both staff positioned the resident on the sling. The Staffing Coordinator picked up the catheter drainage bag and placed it on top of Resident #5's abdomen. The staff then positioned him over his wheelchair and lowered him into his chair and then placed the catheter bag onto the side of his wheelchair. The Staffing Coordinator removed her gloves and left the room with the mechanical lift without performing hand hygiene.<br><br>In an interview with the Staffing Coordinator on 07/22/24 at 10:50 a.m., she stated she was trained to always keep the catheter drainage bag below the bladder. She stated she was just not thinking. She stated placing the bag on the bed could cause a risk of cross contamination. She stated she was supposed to perform hand hygiene after completion of care and before she left the room and she had not done that. She stated she received numerous trainings on hand hygiene.<br><br>In an interview with the DON on 07/24/24 at 10:00 a.m., she stated any resident with a foley catheter should always have the bag and tubing below the bladder and should never be placed on the bed or in the resident's lap. She stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of a urinary tract infection and cross contamination. She stated all the staff were trained numerous times on the expectation of performing hand hygiene after completion of care, after removing gloves and before they left the resident's room. She stated staff were trained on the expectation of sanitizing blood pressure cuffs after each use. She stated to ensure staff were knowledgeable in the care of indwelling catheter, hand hygiene, and sanitation of blood pressure cuff the facility did skills competency checks and she stated she and the ADONs made daily rounds and watched care.<br><br>Record review of the Staffing Coordinator skill checks, dated 04/16/24, reflected she was competent in Indwelling catheter care and hand hygiene.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the facility's policy titled, Hand Hygiene for Staff and Residents, dated January 2022, reflected, Purpose-To reduce the spread of infection with proper hand hygiene .Hand hygiene is done before resident contact .after contact with soiled or contaminated articles, such as articles that are contaminate with body fluids .Resident Contact .toileting or assisting other with toileting, or after personal grooming .removal of medical/surgical or utility gloves .Note: Wash hands at end of procedures where glove changes are not required .Contact with a resident's intact skin .Contact with environmental surface int eh immediate vicinity of resident<br><br>Record review of the facility's policy titled, Disinfecting and Sterilizing Resident Care Equipment dated January 2022, reflected, . non-critical items are those that either do not ordinarily touch the resident or touch only intact skin. Such items include crutches, bed boards, blood pressure cuffs and other medical accessories. These items rarely transmit disease. However, it is imperative that these items are clean.<br><br>42971 |