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	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission for 3 (Resident #3, Resident #13, Resident #30) of 5 residents reviewed for care planning.1.The facility failed to accurately complete the Physician Orders section on the baseline care plan, to indicate Resident #3 was being admitted to the facility with psychotropic medications.2.The facility failed to have a baseline care plan for Resident # 13 and Resident #30 This failure could place newly admitted residents at risk of not having their needs met, not receiving appropriate medications, not receiving necessary treatments, resulting in poor quality of life. 1) Record review of Resident #3's admission MDS Assessment, dated 7/31/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnosis of anxiety disorder. The resident BIMS score was 11 indicating moderately impaired cognition. Section E reflected none of the above for potential indicators of psychosis and no behavioral symptoms. Section N reflected Resident #3 was admitted with Antipsychotic Medication and indication noted. Review of Resident #3's Admit Baseline Care Plan dated 7/28/25 under Physician Orders/Medications/Treatments reflected Resident had no psychotropic therapy. Record review of Resident #3 Physician's Orders dated 7/28/25 reflected Quetiapine Fumarate 50mg tablet (QUEtiapine Fumarate) for G47.00 Insomnia, unspecified ([Start 7/28/25 18:34] 1 tablet by mouth at Bedtime). Record review of Resident #3's Medication Record for 8/1/25 - 8/31/25 reflected administration of Quetiapine Fumarate as ordered each day. 2) Record review of Resident #13's face sheet dated 08/21/2025 reflected she was a [AGE] year-old female with an original admission date of 07/18/2025.Record review of Resident #13's care plan revealed she did not have a baseline care plan.3) Record review of Resident #30s MDS dated [DATE] reflected he was an [AGE] year-old male with an admission date of 07/30/2025, BIMS score of 09 indicated moderate cognitive impairment. His diagnoses included Chronic Obstructive Pulmonary Disease (breathing difficulty).Record review of Resident #30's care plan revealed he did not have a baseline care plan. Interview with the MDS Coordinator on 8/21/25 at 2:35pm revealed she did not complete baseline care plans; she stated the nurse who admitted the resident was responsible for completing the baseline care plan. The risk of not having completed the baseline care plan accurately would be the staff would not know how to provide accurate care and interventions to the resident when they are admitted . Interview with LVN E on 8/21/25 at 3:25pm revealed nurses are responsible for completion of the baseline care plan. LVN E stated the nurses had 24-72 hours to complete a resident's admission which included the baseline care plan. LVN E stated she answered questions on the baseline care plan using notes and residents' assessments. If a resident arrived at the facility with psychotropic medication they would mark psychotropic therapy on the baseline care plan. Seroquel would be considered psychotropic medication and therefore psychotropic therapy would be check marked on the baseline care plan. The risk of not identifying psychotropic medications on the baseline care plan would be all staff wouldn't know what the resident's needs (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were and wouldn't know to monitor the side effects and behaviors. Interview with the DON on 8/21/25 at 4:09pm revealed nurses were responsible for the completion of baseline care plans. The DON stated they got a new electronic record's system on 7/22/25 and the nurses had been struggling to complete the baseline care plan efficiently. The DON reported he was working with nurses' side by side to help teach them the new system. The facility also had super users in the building that helped with major issues with the system. Regarding Resident #3's baseline care plan, Psychotropic therapy should have been checked off for the resident due to him being prescribed Seroquel. The risk of not noting the psychotropic therapy on the baseline care plan was it could have impeded the resident's treatment plan. The DON stated he was unsure of the reason psychotropic medication was not marked on Resident #3's baseline care plan. Review of the facility's policy Person Centered Care Plans revised 6/25/22 reflected .1. The facility must develop and implement a baseline person-centered care plan that meets professional standards of quality care. The baseline care plan will consist of the following: 2. Be developed within 48 hours of a resident's admission. 3. Include the minimum healthcare information necessary to properly care for a resident including but not limited to:.b. physician orders.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 of 5 residents (Resident #3) reviewed for care plan development. The facility failed to complete Resident #3's comprehensive care plan in a timely manner after his comprehensive assessment was completed. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs.Record review of Resident #3's admission MDS Assessment, dated 7/31/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] . Resident #3 had the following diagnoses: Anxiety Disorder, Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood circulation), Heart Failure, Diabetes and Asthma. Section M reflected resident was developing a pressure ulcer. Resident was admitted with the following medications: Antipsychotic, Anticoagulant (blood thinner), Antibiotic, Diuretic and Hypoglycemic (including insulin). Section O reflected resident needed continuous oxygen. Record review of Resident #3's Admit Baseline Care Plan reflected a completion date of 7/28/25.Record request for Resident #3's Comprehensive Care Plan on 8/21/25 at 2:04pm revealed he did not have one completed.Interview with the MDS Coordinator on 8/21/25 at 2:35pm revealed she was responsible for the completion of the Comprehensive Care Plan. The MDS Coordinator stated the expectation was she completed the MDS first and the Comprehensive Care plan would have been completed within 14 calendar days after the resident admitted to the facility. The MDS Coordinator stated she overlooked the care plan for Resident #3 and had not completed his comprehensive care plan yet. The MDS Coordinator stated she would used the CAA, notes from physician, nurses' notes and physician orders to complete the Comprehensive Care Plan. The MDS Coordinator stated psychotropic medications would be on the Comprehensive Care Plan, along with behavioral monitoring and monitoring of side effects. The risk to the resident of not having a comprehensive care plan in a timely manner was staff would not know how to provide accurate care and interventions. The MDS Coordinator completed the following trainings: RAI and Care Planning. The MDS Coordinator also referred to regional resources and trainings when she had questions on completion of the Care Plans. She stated the training for Care Planning was ongoing. Interview with LVN E on 8/21/25 at 3:25pm revealed the MDS Nurse or Unit Manager created and updated care plans. Nurses did not complete care plans. Interview with the DON on 8/21/25 at 4:09 pm revealed the comprehensive care plan was due 21 days from admission. The countdown started from the first day of admission and was calendar days. The nurses were responsible for acute comprehensive care plans, but the CAA triggers were completed by the MDS nurse. He stated Resident #3 should have had his comprehensive care plan completed already. The risk of not having had the care plan done would be it could impede the resident's treatment. He was unsure of the reason the care plan had not been completed. Interview with the Administrator on 8/21/25 at 4:49 pm revealed the expectation was the MDS nurse or nursing staff completed the care plans. The risk to the resident of not having a completed care plan was a lot of things could have gotten messed up and affected the resident negatively. Review of the facility's policy Person Centered Care Plans revised 6/25/22 reflected .Standard of Practice: Each resident will have a person-centered care plan developed and implemented to meet his or her other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.9. Comprehensive Care Plan - must be developed within seven (7) days after completion of the comprehensive assessment, quarterly, annually and with any change of condition.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 (300 Hall Nurses Cart and 200 Hall Nurses Cart) of 4 medication carts reviewed for pharmacy services in that:The facility failed to ensure: 1- 300 Hall Nurses Cart did not have:o 1 insulin pen for Resident #64 without an open date on 08/19/25. o 1 insulin pen for Resident #58 without an open date on 8/19/25. o 1 insulin pen for Resident #7 without an open date on 08/19/25. o 1 insulin pen for Resident #51 without an open date on 08/19/25. 2- 200 Hall Nurses Cart did not have: o 1 insulin pen for Resident #44 without an open date on 08/19/25. These failures could affect residents resulting in diminished effectiveness and not receiving the therapeutic benefits of the medications.1- Record review and observation on 08/20/25 at 8:56 AM of the 300 Hall Nurses Cart, with RN A revealed: - The pen of insulin Lispro 100 unit/ml for Resident #64 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use. - The pen of insulin Novolog 100 unit/ml for Resident #58 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use.- The pen of insulin Lispro 100 unit/ml for Resident #7 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use.- The pen of insulin Lantus 100 unit/ml for Resident #51 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use Interview on 08/19/25 at 9:21 AM, RN A stated nurses were responsible to check the medication carts and the insulin pens for the open dates before giving insulin. He stated the nurse was supposed to label the pen with the open date when first opened. RN A stated the purpose of putting an open date was for expiration purposes because the insulin was only good for 28 days. He stated after 28 days the insulin would be ineffective. 2- Record review and observation on 08/19/25 at 9:27 AM of the 200 Hall Nurses Cart, with LVN I revealed: The pen of insulin Lantus 100 unit/ml for Resident #67 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use. Interview on 08/19/25 at 9:45 AM, LVN I stated nurses were responsible to check the medication carts and the insulin pens for the open dates before giving insulin. She stated the insulin was good for 28 days only after opened, after 28 days the insulin should be discarded because its effectiveness decreased. Interview on 08/20/25 at 3:42 PM, the DON stated the insulin flex pens and vials, once opened, needed to be dated because each insulin pen and vial had a specific day's shelf life and if not thrown out by that time the insulin could lose its effectiveness. The DON stated the pharmacy consultant checked the carts monthly and he stated he would do random checks of the medication carts for monitoring.Record review of the facility's policy titled Medication Storage, dated January 2024, reflected . Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in:1. The facility failed to ensure food items in the facility walk-in refrigerator, walk-in freezer and dry storage were dated or labeled.2. The facility failed to ensure food stored in the freezer were properly closed and sealed to prevent exposure to the air. 3. The facility failed to ensure during lunch service kitchen staff used proper hand hygiene while serving residents' trays on 8/19/25.4. The facility failed to take temperatures of all food being served during lunch service on 8/19/25.5. The facility failed to place serving spoons on a sanitized surface during lunch services on 8/19/25.These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination.Observation of the walk-in refrigerator and an interview with the Dietary Manager on 08/19/2025 at 8:47 am revealed: -a clear plastic sealed gallon-sized bag with 3, 8-ounce globs of thick white substance with no label of contents. The Dietary Manager stated it was cream cheese.-a clear plastic sealed gallon-sized bag with about a 1/4 full of small black 1-centimeter circular items without a label of contents. The Dietary Manager stated they were chocolate chips. She stated everything should have been labeled with what the contents were and should have had a date received and date opened. Observation of the walk-in freezer and an interview with the Dietary Manager on 8/19/25 at 8:57 am revealed: - a 20-lb opened box of beef patties, with about 65 patties left, in plastic bags opened to the air and not sealed. The Dietary Manager stated all food must be sealed and closed appropriately when in the freezer to prevent freezer burn. Observation of the dry goods storage area on 8/19/25 at 9:00 am revealed: -3, 5-lb bags of manufacture sealed plastic bags, filled with about 1 cm beige objects with no label of what the item was.-17 small plastic 2oz cups with lids and a brown liquid substance, not labeled with contents. An interview with the Dietician on 8/19/25 at 10:45 am revealed she had been helping the Dietary Manager because she was new to the position. She stated all items in refrigerator, freezer, and dry storage should be labeled with date received, date opened, and list the name of the item. She stated all food that was opened should be sealed. She stated the box of patties should be sealed and not opened to the air. She stated the 3 bags of beige items were rice crispy cereal and should be labeled when they removed them from their original box. She stated the risk to the residents of not properly labeling the items would be wrong items could be served to residents. The risk to residents of the frozen patties not being sealed appropriately would be freezer burned and poor-quality food. Observation of lunch service on 8/19/25 at 11:54am revealed the Dietary Manager was cooking gravy on the stove. She then poured the gravy in the warming tray. [NAME] M nor Dietary Manager temped the food before serving the gravy to the first resident. Observation of lunch service on 8/19/25 at 12:15 pm revealed two metal serving spoons on the metal counter in front of the warming food. [NAME] M's clothing was rubbing back and forth on the counter where the spoons were placed. [NAME] M grabbed one of the metal spoons on the counter and put it in the pureed meat and proceeded to serve a meal tray. Observation of lunch service on 8/19/25 at 12:40 pm revealed [NAME] M left the serving area with her gloves on and went to the freezer to grab frozen fries. She returned to the serving area with the same gloves and poured the fries from the bag into the fryer. She left the fries frying and took the frozen fries back to the freezer with the same gloves on. When she returned to the serving area, she had removed the gloves, but had not washed her hands. She then put a new set of gloves on and continued to serve food. She removed the fries from the fryer, poured them on to a plate, and handed the plate to the Dietary Manager who served them immediately and did not temp them. Observation of lunch service on 8/19/25 at 12:45 pm revealed the Dietary Manager asked [NAME] M for the oatmeal. [NAME] M got the cooked oatmeal that was already served and being held in a warmer and handed it to the Dietary Manager. The Dietary Manager (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed the plastic covering over the oatmeal container, did not temp it, and served it on a tray. Interview with the Dietician on 8/19/25 12:50 pm revealed all food, to include gravy, fries, and oatmeal should have been temped. The Dietician stated the only item that should not need temping was bread. The risk to the resident of not temping all food was food borne illness and potentially undercooked food. The serving spoons were all sanitized and the counter should have been sanitized as well, however, since [NAME] M's clothing was touching the counter and the spoons were on it then there would be a risk for cross contamination. Regarding the observation of [NAME] M not washing hands between glove changes, she stated she corrected her once during the observation and would in-service her again. [NAME] M stated the risk to the residents of in-proper hand hygiene during food service was cross contamination. Interview on 8/20/25 at 10:37 am with the Dietary Manager revealed the expectation for hand washing for kitchen staff was for them to wash their hands after every change of gloves or change of tasks. The risk to the resident of kitchen staff not washing their hands appropriately was residents could have gotten sick due to cross contamination. The Dietary Manager stated kitchen staff was in-serviced monthly on hand hygiene and they in-serviced them yesterday as well. The Dietary Manager stated the expectation for labeling was everything should be labeled and the risk to the resident of not labeling items was they may be served something they could not or should not be eating. The expectation for food temperatures was all food must be temped and there was no exception to that rule. The Dietary Manager stated it was the cook's responsibility to temp all food, but she temped foods at times. The risk to the resident of not temping food was they could be serving raw food and make residents sick. Interview with [NAME] M on 8/21/25 at 10:20 am revealed when an item was opened it needed to be put in a secured bag with a label of what it was, date opened, and the used- by date. [NAME] M stated kitchen staff needed to wash hands all the time. She stated their hands must be washed after gloves were taken off and before gloves were put on. The risk to the resident of improper hand hygiene and improper labeling was possible sickness or cross contamination. [NAME] M stated serving spoons should be taken off the wall and placed directly in the food and not on dirty surfaces. All food needed to be temped, both hot and cold. The risk of not temping the food was staff may not know if the food was fully cooked. [NAME] M stated she had been in-serviced already on hand hygiene. Interview with the Administrator on 8/21/25 at 4:49 pm revealed the expectations on food temperatures was all foods needed to be temped before serving. The Administrator stated the expectation for hand hygiene in the kitchen was once staff stepped away from the serving line to do something else, staff must wash your hands. The Administrator stated dietary staff needed to wash their hands before they put on new gloves and after they removed used gloves. The risk to the residents of not using proper hand hygiene was a break in infection control. The risk to the resident of not taking all temperatures on food before it was served was food might not be held at the right temperature and could be served to the resident. The expectation on labeling was all foods should be labelled with contents, date opened, and date use by. Review of the facility's policy Hot and Cold Food Temperatures revised 2/6/24 reflected: .Procedure: 1. Cooking temperatures must be achieved and maintaining according to recipes and regulations. 2. Hot temperatures will be taken and recorded prior to service to ensure foods are at or above 135.Review of the facility's policy Employee Infection Control revised 4/8/25 reflected .7. Employees will wash their hands before handling food in preparation. 8. Employees will clean and sanitize equipment and work areas after use and when changings tasks.Review of the facility's policy Food Storage revised 4/8/25 reflected .Storeroom.airtight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened.Refrigerator.all foods are covered, labeled and dated.Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 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 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be identified with the common name of the food 3-305.11 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section for 1 of 5 residents (Resident #3) reviewed for unnecessary medications.1.The facility failed to have an adequate indication for the use of the medication Quetiapine Fumarate (Seroquel - an antipsychotic) for Resident #3. 2. The facility failed to monitor behaviors and side effects of Quetiapine Fumarate (an antipsychotic) for Resident #3. The failures could place residents at risk of increased behaviors, negative outcomes, adverse reactions and even a decline in health.Record review of Resident #3's admission MDS Assessment, dated 7/31/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had a diagnoses of anxiety disorder. The resident's BIMS score was 11, indicating moderately impaired cognition. Section E reflected none of the above for potential indicators of psychosis and no behavioral symptoms. Section N reflected Resident #3 was admitted with Antipsychotic Medication with indication noted. Review of Resident #3's Admit Baseline Care Plan dated 7/28/25, reflected the resident had no psychotropic therapy. Record review of Resident #3 Physician's Orders dated 7/28/25 reflected Quetiapine Fumarate 50mg tablet (QUEtiapine Fumarate) for G47.00 Insomnia, unspecified ([Start 7/28/25 18:34] 1 tablet by mouth at Bedtime). No order for behavior monitoring or side effect monitoring was found. Record review of Resident #3's Medication Record for 8/1/25 - 8/31/25 reflected administration of Quetiapine Fumarate as ordered each day. The record did not include documented evidence the facility was monitoring for side-effects related to the use of the Quetiapine Fumarate or monitoring the resident's behaviors for signs of psychosis. Record review of progress notes for Resident #3 dated 7/28/25 to 8/21/25 did not reveal any documented behavioral or psychotic issues. Interview with LVN B on 8/20/25 at 1:53pm revealed Resident #3 had no significant behavioral issues and no major incidents since admittance to the facility. She stated Resident #3 was receiving psychiatric services for anxiety and was receiving Quetiapine Fumarate for depression. She stated there was no order to monitor his behaviors, but she monitored his behaviors due to his medications. She stated the nurses were supposed to chart how many episodes a resident had each shift, and it should have been documented in the MAR. She stated she was not currently charting any behaviors because she was learning the facility's new electronic record system. She stated the risk of not monitoring behaviors could lead to other problems such as over treatment and increased psychiatric symptoms. She stated if Resident #3 was having behaviors she would report to the ADON, DON and Administrator. She stated she could also reach out to the doctors immediately if residents had acute needs. She stated the last time she was in-serviced on monitoring behaviors was about 2 weeks ago. Interview with ADON F on 8/20/25 at 2:50pm revealed Resident #3 was being prescribed Seroquel (Quetiapine Fumarate) for mood and bipolar disorder. When questioned about the physician's order stating it was for Insomnia, she stated Resident #3 came from the hospital with that medication. ADON F stated insomnia was not an appropriate diagnosis for the use of Seroquel and stated the corrected diagnosis needed to be entered on the orders. ADON F stated there should have also been an order monitoring the resident's behaviors and side effects related to the psychotropic medications. Behaviors and side effects should have been monitored every shift and documented on the MAR. The risk of not documenting an adverse reaction to the medication would be the doctor would not have gotten a clear picture of how the resident was doing and therefore couldn't take the appropriate actions. Behavior monitoring was important to make sure (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patients were safe. If behaviors were not documented, then it puts the resident at risk of being over or under medicated . Interview with the DON on 8/20/25 at 3:12pm revealed antipsychotic medications were verified with the doctor upon a resident's admission. If a resident was admitted with psychotropic medication, they would ask the social worker to make a referral for psychiatric services. If the hospital discharged a resident with a psychotropic medication and the order stated it was for insomnia, they should have spoken to the doctor about it because insomnia was not an appropriate diagnosis for psychotropic medication. The facility should have an order for monitoring behaviors and monitoring side effects when the residents were taking anti-psychotic medications, regardless of the medical diagnosis used to prescribe it. The monitoring of behaviors would help to monitor the resident's medication and the need for it. The risk of not having an order to monitor the behaviors and side effects would be dependent on the skills set of the nurse, and whether they knew what behaviors and side effects to look for with residents on anti-psychotic medications . Interview with ADON G on 8/20/25 at 3:54pm revealed all psychotropic medications prescribed should have an appropriate diagnosis for the use of the medication. Insomnia would not be an appropriate diagnosis for an anti-psychotic medication like Seroquel. The facility should also have an order for behavior monitoring and monitoring of adverse reactions and it should be documented in the TARs and MARs. The risk to the resident of not having had an appropriate diagnosis for antipsychotic medication was the resident may have no longer needed the medication. The risk to the resident of not having an order for side effects or behaviors was the doctor wouldn't know if the medication was effective. Review of the facility's policy Psychotropic Drugs - Use reflected Purpose: 1. The community will use psychotropic drug therapy when appropriate to enhance the qualify of life, while maximizing functional potential and well being of the patient/resident. 2. Qualified staff will monitor the patient/resident for potential undesirable side effects that are associated with the use of psychotropic drugs according to CMS, State specific rules and regulation and Practice Guidelines.Standard of Practice:.B. Antipsychotics: Only appropriate for the following acceptable diagnosis(es):*Schizophrenia *Huntington's disease *Tourette's syndrome. Antipsychotic drugs are not used if one or more of the following is/are the ONLY indication:.7. Insomnia.Note: Careful evaluation of the residents' records should be reviewed for appropriate diagnosis for medication use.

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Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 6 residents (Residents #66, #38) reviewed for care plans.1. The facility failed to develop the following comprehensive person-centered care plans for Resident #66: playing music calmed her her representative preferred her nightstand lamp to stay on at night the need for bilateral (left and right) palm guards due to hand contractures.2. The facility failed to develop a comprehensive person-center care plan that reflected Resident #38 preferred to have her medication placed in her hand, one at a time, during medication administration due to being legally blind. These deficient practices could place residents at risk of not receiving the necessary care or services.Findings included:1. Record review of Resident #66 Quarterly MDS assessment, dated 07/20/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (loss of cognition), anxiety (feelings of intense worry), and depression (feelings of sadness/loss of interest). Review of Section N- Medications- N0415. High-Risk Drug Classes- reflected she was taking antipsychotic, antianxiety, and an antidepressant. N0450. Antipsychotic Medication Review reflected the resident received antipsychotic medications on a routine basis and a gradual dose reduction (GDR) had not been attempted, the physician had not documented the GDR as clinical contraindicated. Review of Section O- Special Treatments, Procedures, and Programs reflected there were no days of restorative programs performed for a splint or brace assistance.Record review of Resident #66's care plan, printed 08/19/25, reflected she was a fall risk related to contractures and paralysis with an onset date of 10/07/24, and reviewed and continued 05/06/25. Interventions included anticipate resident's needs, check frequently, low bed, and therapy referral. Review of the care plan revealed no documentation that playing music calmed Resident #66. Review revealed no documentation that Resident #66's representative preferred Resident #66's nightstand lamp to stay on at night. Review of the care plan revealed no documentation that Resident #66 required bilateral (left and right) palm guards due to hand contractures.Record review of Resident #66's Kardex, printed 08/19/25, reflected blank spaces for what the resident enjoyed to do, what made life meaningful to the resident, and contracture devices. Record review of Resident #66's physician orders, printed 08/21/25, reflected no orders for palm guards or contracture devices.In an observation on 08/19/25 at 10:19 AM of Resident #66, she was asleep in bed on the lowest position with music playing from a music player on her nightstand next to her bed wearing a palm guard to her left hand. There was a sign on the wall that reflected: Music calms her-helps if she is yelling turn CD player on and a sign on the lamp on her nightstand that reflected: please leave light on at night, thank you. In an interview on 08/19/25 at 1:23 PM with Resident #66's representative, she stated she had put up the signs to ensure staff were aware of what helped Resident #66 to be calmer and the staff were good about following the interventions. She stated she participated in care plan meetings. She stated she was not sure if it was something they discussed during the care plan meetings. She stated she frequently visited Resident #66 and saw that staff were aware of the Resident's needs.An observation on 08/20/25 at 12:05 PM revealed Resident #66 was lying in bed and mumbling incoherently and was wearing a palm guard to her left hand. An interview on 08/20/25 at 12:10 PM with MA J revealed Resident #66 was not able to communicate coherently and sometimes yelled out in agitation. MA J stated Resident #66 was calmed when they played music that was on her nightstand, and she was aware because of the signs posted in Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#66 room by the representative. She stated she was not sure if Resident #66's music and lamp light staying on at night, or palm guard were care planned. She stated she knew of Resident #66's interventions because of the signs in her room. She stated staff were informed during change of shift of residents needs and she was able to see the Kardex and Medication Administration Record (MAR).An interview on 08/21/25 at 9:09 AM with CNA H revealed Resident #66 had on a palm guard to her left hand and none on her right hand. Observation of Resident #66's right and left hands with CNA H revealed her nails were trimmed with no jagged areas and the skin of her palms had no injuries. CNA H stated that the CNAs only had access to the Kardex and if there were resident preferences, CNAs were informed by nursing management or during change of shift and could find information in the Kardex. She stated she was aware that music helped Resident #66 calm down because other staff told her and she followed the signs the representative had placed in Resident #66's room. In an interview on 08/21/25 at 9:16 AM with CNA K, she stated she was the restorative aide for the facility. She stated Resident #66 was not currently on restorative services and had a hand brace due to a contracture.In an interview on 08/21/25 at 9:28 AM with the Director of Rehabilitation Services revealed Resident #66 had been assessed upon admission and quarterly. She stated Resident #66 was not currently on therapy services. She stated that she did not see any orders for a palm guard and the resident was on their contracture log which noted she had bilateral palm guards. She stated with the facility transferring to a new electronic health record, she was not sure if Resident #66 had an order for the bilateral palm guards. In an interview on 08/21/25 at 9:35 AM with LVN I, she stated Resident #66 was typically in bed, and Resident #66's Representative had brought the music player and told staff that it helped to relax Resident #66 and it really helped Resident #66. She stated she was not sure if the intervention of playing music for Resident #66 was care planned and thought it would be helpful because if a new staff member came to care for Resident #66, they would know what helped the resident. In an interview on 08/21/2025 at 2:57 PM, ADON L stated Resident #66 was nonverbal, mumbled incoherently, and occasionally yelled out. She stated the signs that indicated music calmed Resident #66 and to leave the nightstand light on at night should be care planned. She stated the care plan informed staff of residents' needs and preferences. She stated she wasn't aware until today about Resident #66's need for palm guards and stated it was important to care plan her need so that everyone was aware for her to have it on to prevent injuries of her palm from her nails. In an interview on 08/21/25 at 12:38 PM with the DON, he stated that Resident #66's need for palm guards, keeping the bedside lamp light on a night, and music that calmed her, should be care planned and he was not aware that it was not care planned. He stated that the MDS Coordinator was responsible for updating care plans and they were reviewed in morning meetings, quarterly, or upon change of condition. He stated the facility had switched to a new electronic medical record system and they were going to continue to audit care plans. He stated it was important for care plans to reflect a resident's needs and preferences, so they were honored by staff. In an interview on 08/21/25 at 2:35 PM with the MDS Coordinator, she stated she was responsible for updating care plans during morning meetings, upon a change of condition, or quarterly. She stated she was not aware of the signs in Resident #66's room that stated music was calming or about the lamp light staying on at night. She stated it would be something that should be care planned because it helped staff know what helped the resident. She stated the resident requiring palm guards should also be something that was care planned and she was not aware until now and if it was not care planned then staff might not know that the resident needed to wear a palm guard. She stated it was important that care plans reflected a resident's preferences to ensure their preferences were honored and was going to update Resident #66's care plan. 2. Record review of Resident # 38's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses of stroke, kidney failure, and hypertension (high blood pressure), severely impaired vision, and intact cognition. Record review of Resident #38's care plan, printed 08/21/25, reflected she had a visual impairment due to being legally blind and interventions included keep furniture in same place, keep most frequently used items in a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consistent area within reach, dated 01/13/25. The interventions did not reference any preferences for medication administration. Further review reflected Resident #38 resisted care as manifested by: refusing medications after medication aide gives them to her and telling her which medication is which and it happens only during the morning med pass. with a goal to have less than 3 episodes per week, dated 08/14/25. Review revealed no documentation that Resident #38 preferred to have her medication placed in her hand, one at a time, during medication administration due to being legally blind. Interventions included administer medications as ordered, approach calmly, explain why procedures and care are needed before provided, and allow highest level of independence when making choices regarding care.In an interview on 08/19/25 at 11:00 AM with Resident #38, she stated that she was legally blind and during medication passes she preferred staff to tell her what the medication was and hand it to her in her hand so she could feel the pill because it reassured her. She stated she knew what her medications felt like and could make out some colors. She stated that she was not sure if it had been mentioned in care plan meetings and usually staff administered her medications to her by her preference except for a recent interaction with a new medication aide which the facility was responsive in addressing and informed her that the aide would no longer pass her medications, and the nurse was going to pass her medications. In an interview on 08/20/25 at 12:10 PM with MA J, she stated that she had passed medication to Resident #38 when she first started working at the facility and when she put them in a cup and handed them to Resident #38 she would not take them and requested to be informed of which pill she was being handed and it be placed in the palm of her hand so she could feel it. She stated she knew now that Resident #38 preferred medication administration a certain way because she was legally blind and knew the shape and color of the medications she took. She stated she was not aware if it was care planned and would typically look at the Kardex or was informed by nursing staff about resident preferences. In an interview on 08/21/25 at 9:35 AM with LVN I, she stated that Resident #38 was blind and during medication passes she wanted staff to tell her what the medication was and placed in the palm of her hand so she could feel the medication shape and sometimes could make out colors. LVN I stated she was not sure if that was care planned. She stated it would be important to care plan Resident #38's preference for medication pass to ensure her preferences were honored. In an interview on 08/21/25 at 9:18 AM with RN A, he stated Resident #38 was legally blind and during medication passes she wanted staff to tell her what each medication was, one at a time, then placed in her hand so she could feel the shape of the medication. He stated that if he was passing medications to her, he took her to wash her hands then proceeded to give her medications using her preferred method. He stated she requested medications be given in this way every time he passed medications to her. He stated he was not sure if it was care planned and stated it would be important to care plan to ensure all staff knew of the resident's preferences. In an interview on 08/21/25 at 12:38 PM with the DON he stated he was aware Resident #38 was legally blind and had heard the team speak about her preference for medication administration by placing the medications in the palm of her hand. He stated Resident #38's preference for medication administration should have been care planned to ensure her preferences were honored by staff and that staff were aware. In an interview on 08/21/25 at 2:35 PM with the MDS Coordinator, she stated she was aware that Resident #38 preferred the nurse to put the medications in the palm of her hand and she had updated the care plan after a medication aide had attempted to give Resident #38 her medication in a cup and Resident #38 refused her medications. She reviewed Resident #38's care plan and stated she could see how the updated care plan on 08/14/25 could've been made to seem more like a behavioral concern of refusing medications rather than a preference due to the resident being legally blind and wanting the medication in her palm so she could feel the medication. She stated person-centered care plans were important to ensure residents received their plan of care. In an interview on 08/21/2025 at 2:57 PM with ADON L, she stated Resident #38 was legally blind and during medication administration she liked to have the pills placed in the palm of her hand because it reassured Resident #38 because she knew what the pills (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	felt like and could make out some colors. ADON L stated she was not sure if Resident #38's care plan was updated to reflect her preference and the MDS Coordinator was responsible for updating resident care plans. ADON L stated it was important to care plan Resident #38's medication administration preference so that other people were aware of her residents preferences and if a new staff member was going to work with the resident, they would be able to look at it and learn the resident too.In an interview on 08/21/25 at 4:43 PM with the Administrator, he stated that it was important to ensure a resident's care plan was as personalized as possible and would have expected Resident #66 and Resident #38's preferences to be care planned. He stated it was important for care plans to personalized so residents received the care they needed. The Administrator stated the MDS Coordinator was responsible for updating resident care plans and they were reviewed and updated upon change of condition, admission, and quarterly. Record review of the facility's care plan policy, titled Care Planning and dated revised 10/24/22 reflected: .To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs . Each resident's Comprehensive Care Plan will describe the following: A. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #56) of 6 residents reviewed for ADLs. The facility failed to ensure Resident #56 had his fingernails cleaned and trimmed on 8/19/25. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Record review of Resident #56's Quarterly MDS assessment dated [DATE] reflected Resident #56 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident (a condition that occurs when blood flow to the brain is blocked. The blockage can lead to brain tissue death.), and elevated blood pressure. Resident #56's BIMS score of 14, indicated Resident #56' cognition was intact. The MDS assessment indicated Resident #56 required maximal assistance with bathing. Record review of Resident #56's Care Plan revised 07/02/25, reflected the following: Care area: Self-care deficit . Goal: [Resident #56] will accept assistance with area of dressing, grooming hygiene and bathing over the next 90 days . Interventions: . provide assistance with self-care as needed. In an observation and interview on 08/19/25 at 10:24 AM revealed Resident #56 was lying in his bed. The nails on both his hands were approximately 0.3cm in length extending from the tip of his fingers. The nails were discolored tan and had brownish colored residue on the underside. Resident #56 stated he did not like his nails long and dirty and he did not tell staff because they were busy. In an interview on 08/19/25 at 2:08 PM, LVN I stated CNAs and nurses were responsible to clean and cut the residents' nails. LVN I stated she did not notice Resident #56's nails. She stated she would do it right then. She stated the risk would be infection control and injury. In an Interview on 08/20/25 at 3:42 PM, the DON stated nail care should be completed as needed and every time aides washed the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated he expected CNAs and nurses to offer to cut and clean nails if they were long and dirty. The DON stated the ADONs would do the routine rounds to monitor. The DON stated residents having long and dirty nails could be an infection control issue and skin break down if scratching. Record review of the facility's policy ADLs/Bathing revised February 2020, did not address the concern of fingernails care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 6 (Resident #66) reviewed for range of motion. The facility failed to implement interventions to prevent further decline of Resident #66's contracture to her left hand on 04/22/25. The facility failed to ensure physician orders were written for bilateral (left and right) palm guards for Resident #66 on admission on [DATE].This failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Findings included: Record review of Resident #66 Quarterly MDS assessment, dated 07/20/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (loss of cognition), anxiety (feelings of intense worry), and depression (feelings of sadness/loss of interest). Review of Section O- Special Treatments, Procedures, and Programs reflected there were no days of restorative programs performed for a splint or brace assistance.Record review of Resident #66's care plan, printed 08/19/25, reflected she was a fall risk related to contractures and paralysis dated onset of 10/07/24, and reviewed and continued 05/06/25. Interventions included anticipate resident's needs, check frequently, low bed, and therapy referral. Record review of Resident #66's Kardex, printed 08/19/25, reflected blank spaces for what the resident enjoyed doing, what made life meaningful to the resident, and contracture devices. Record review of Resident #66's current physician orders did not indicate an order for a palm hand guard. Record review of Resident #66's Kardex, printed 08/19/25, reflected a section for contracture devices was blank. Record review of Resident #66's admission record, dated 10/07/24, active order summary reflected an order for palm protector to left hand with an order start date of 10/21/21. Further review revealed page noting the Resident Representative's notes for Resident #66's care that included Fussy Behavior: If she shouts out, she is usually in pain or anxiety.Nighttime: Blue brace on left arm comes off and is replaced with smaller white brace. This is so she doesn't cut her hands with her fingernails. [NAME] brace can stay on right hand. (can come off for a few hours if it bothers her). Morning: Put blue brace back on. [NAME] brace can stay on right hand.Record review of Resident #66's treatment administration record for the month of August 2025 did not reflect a palm guard. Record review of the facility's contracture log reflected Resident #66 had a contracture to her left and right elbows flexion (bent) and her left and right hands and was on staff management. Resident #66 was last treated on 10/31/25 for physical and occupational therapy and was previously screened on 07/18/25. Resident #66 had bilateral (left and right) palm guards. Record review of Resident #66's therapy screening, dated 07/18/25, reflected she had contractures to both elbows in flexion (bent) and both hands. Further review reflected palm guards for [bilateral] hand contractures are managed by nursing staff, pt has had no functional changes and no skilled PT/OT/ST services are warranted at this time. with recommendations to continue current interventions. In an interview on 08/21/25 at 12:38 PM with the DON, he stated that Resident #66 had been assessed by the therapy department upon admission and most recently on 07/18/25 where the recommendation was to continue bilateral palm guards for her hand contractures. An interview and observation on 08/21/25 at 9:09 AM with CNA H revealed Resident #66 had on a palm guard to her left hand and none on her right hand. Observation of Resident #66's right and left hands with CNA H revealed her nails were trimmed with no jagged areas and the skin of her palms had no injuries. CNA H stated that the CNAs only had access to the Kardex and if there were resident preferences, CNAs were informed by nursing management or during change of shift and could find information in the Kardex. She stated she was aware that music helped Resident #66 calm down because other staff told her and she followed the signs the representative had placed in Resident #66's room. In an interview on 08/21/25 at 9:16 AM with CNA K, she stated she was the (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restorative aide for the facility. She stated Resident #66 was not currently on restorative services and had a hand brace due to a contracture.In an interview on 08/21/25 at 9:28 AM with the Director of Rehabilitation Services revealed Resident #66 had been assessed upon admission and quarterly. She stated Resident #66 was not currently on therapy services. She stated that she did not see any orders for a palm guard and the resident was on their contracture log which noted she had bilateral palm guards. She stated with the facility transferring to a new electronic health record, she was not sure if Resident #66 had an order for the bilateral palm guards. In an interview on 08/21/25 at 9:35 AM with LVN I, she stated Resident #66 was typically in bed and she had a contracture to one hand and wore a palm guard. She reviewed the contracture log and stated she was not aware that the resident had bilateral contractures and palm guards to both hands and was only aware of one hand having the palm guard. She stated she would have expected there to be an order for the palm guards so it would show up in the treatment administration record. She stated she was not sure if there was a physician order for the palm guards and stated that it was important to ensure the resident wore the palm guards and if there was no order then no one would know that the resident wore palm guards. In an interview on 08/21/25 at 1:24 PM with the Medical Director revealed he was Resident #66's physician for many years before she admitted to the facility in October of 2024. The Medical Director stated he was not aware that there was no order for bilateral palm guards for Resident #66 and he was not sure why they did not transfer over from her admission in October, 2024. He stated there should be a physician order, and he visited the facility multiple days per week and signed orders in batches. He stated it was important to ensure there was a physician order for palm guards so the treatment was provided to the resident. In an interview on 08/21/2025 at 2:57 PM ADON L, she stated she wasn't aware until today about Resident #66's need for palm guards and did not know there was not an order for the palm guards. ADON L stated it there should be a physician order or physical therapy order was important to have for Resident #66 to ensure that palm guards had been evaluated by the physician or physical therapy and ensure it was followed by staff to prevent injuries of her palm from her nails.Record review of the facility's policy on admitting residents titled Admitting a Resident, dated reviewed April 23, 2024, reflected: Nursing staff will admit the resident to the community in accordance with applicable law and regulation, as well as helping the resident with adjustment to his/her new surroundings and initiating the appropriate assessments and the Plan of Care.The licensed nurse reviews transfer papers that accompany the resident.Record review of the facility's policy on rehabilitation services titled Clinical Policies and Procedures: Subject: Resident Screening Form, dated revised 01/01/2025, reflected: The screening process will provide a means of providing rehabilitation information into the care plan process for newly admitted patients, referrals, and established patients on a quarterly basis, as well as to indicate the need for an evaluation and aid in determining the patient's ability to participate in a skilled rehabilitation program. Review the following examples of the type of medication conditions and changes which should be monitored for appropriate therapy referrals (this list is not all inclusive). progressive joint contractures.review the following documentation during the screening process: . admission sheet, physician notes or history and physical.physician order sheet.patient care plan.Record review of the facility's policy on physician orders titled Physician Orders-Electronic, dated reviewed November 27, 2023, reflected: Policy:1. The licensed nurse will receive and transcribe the physician's orders according to the Practice Guidelines. 2. The licensed nursing staff will provide resident with medications and treatments as ordered by his/her physician.Procedure.2.The licensed nurse clarifies and reconciles all orders that may lead to an administration error. 3. The electronically entered order will be automatically transcribed onto the Medication admission Record (MAR) or Treatment Record.

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Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 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 for one (Resident #41) of two residents reviewed for incontinence care. The facility failed to ensure CNA P provided appropriate perineal care for Resident #41 after an incontinent episode when she failed to clean the resident's labia on 08/19/25. This failure could place residents at risk for the development and/or worsening of urinary tract infections. Record review of Resident #41's Quarterly MDS assessment dated [DATE] reflected Resident #41 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), and elevated blood pressure. Resident #41's BIMS score of 03, indicated Resident #41's cognition was severely impaired. The MDS assessment indicated Resident #41 was frequently incontinent of bowel and bladder. Record review of Resident #41's Care Plan reviewed 07/14/25, reflected the following: Problem: At risk for problems with elimination. Goal: Resident's elimination status will be maintained or improved over the next 90 days. Interventions: . provide incontinent care after each incontinent episode .In an observation on 08/19/25 at 2:56 PM revealed CNA P entered Resident #41's room to provide incontinence care. CNA C washed her hands and put on gloves and unfastened the brief to reveal the resident had been incontinent of urine. CNA P pushed the soiled brief down between the resident's legs, toward her buttocks and cleaned her peri area (the area of skin between the anus and the external genitalia) from the front to back but did not separate the labia and clean down the middle. CNA C rolled the resident onto her side revealing the resident had soaked through her brief. CNA C continued to provide incontinence care, wiping the resident's buttocks from back to front and reapplied a clean brief. She removed her gloves and washed her hands. An interview with CNA P on 08/19/25 at 3:02 PM revealed she failed to separate the resident's labia, and she wiped the resident's buttocks from back to front and by providing inappropriate incontinent care that could lead to an infection. She stated she had been in training and knew the importance of properly cleaning a resident. In an interview on 08/20/25 at 03:42 PM, the DON stated when providing incontinent care, staff were to clean the peri area including the labia for female residents, then moving toward the buttocks and always clean from the front to back. He stated by not providing accurate incontinent care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. He stated he would monitor by doing skills check on all CNAs periodically. Record review of the facility's policy titled, Perineal Care/Incontinent Care, dated April 2012, reflected, .For female patient/resident: Separate the labia and wash downward (down the center of labia), then downward on each side of the labia using a different per wipe with each stroke.Clean outer hip of buttocks going upwards towards back .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 4 residents (Resident #12) reviewed for quality of care. The facility failed to ensure LVN I followed physician ordered water flushes between each medication administration given via the G-Tube (a feeding tube surgically inserted through a small opening in the abdomen directly into the stomach, used to deliver nutrition, fluids, and medications when a person cannot ingest enough by mouth) for Resident #12 on 08/20/25. This failure could place residents at risk of nausea, shortness of breath and a decrease potential fluid overload. Record review of Resident #12's Comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male with an admission date 11/13/23. Diagnoses included traumatic brain dysfunction (brain dysfunction caused by an outside force), respiratory failure (lungs can't properly exchange gases) and gastroesophageal reflux (condition where stomach contents back up into the esophagus. Nutritional status revealed Resident #12 had a G-Tube.Record review of Resident #12's care plan reviewed on 06/09/25 reflected, Care Area: Presence of G-Tube . Goal: Resident will have no signs or symptoms of aspiration over the next 90 days . Interventions: Keep the head of the resident's bed at 30 degree and 45 degree, . Provide water flush as ordered, . Provide water flush at med pass per nursing policy. Record review of Resident #12's August 2025 Physician's order sheet report reflected, .G-Tube Flush 30 cc water before and after medications . Use 15 cc water flush in between each medication administered . with a start date of 07/25/25. An observation on 08/20/25 at 9:31 AM of G-Tube medication administration revealed LVN I prepared medication for Resident #12. LVN I placed 1 tablet of Baclofen 10 mg (muscle relaxant), 1 tablet of folic acid 1mg (B vitamin), 1 tablet of furosemide 40 mg (water pill), 1 tablet of vitamin C 500 mg, 1 tablet of vitamin B1, and 1 tablet of multivitamin with minerals in an individual cup and crushed each tablet. LVN I placed the 6 medication cups and a cup filled with approximately 8 ounces of water on a tray and entered the resident's room. LVN I poured approximately 10 cc of water into each medication cup and then retrieved a 60-cc piston syringe (a medical device with a hollow barrel and a plunger that creates a seal to draw in or expel fluids for medical uses) and placed the piston syringe into the G-tube connector and checked for residual. LVN I then flushed the G-tube with 30 cc of water and then administered the first medication by gravity and she did not flush the tube feeding with water; she administered the second medication by gravity and she did not flush the tube feeding with water; she administered the third medication by gravity and she did not flush the tube feeding with water; she administered the fourth medication by gravity and she did not flush with water; and she administered the fifth medication and then the sixth by gravity. She then flushed with 10 cc of water and then 30 cc of water. LVN I then reconnected the feeding tube and turned the pump back on. In an interview with LVN I on 08/20/25 at 9:56 PM she stated she was not required to flush the G-tube with water before and after each med pass. When LVN I looked at the medication administration record, she stated Oh it was supposed to be 10 ml of water after each medication. She stated she overlooked the orders. She stated she was required to review with physicians' orders prior to giving any medication and clarify if it was not clear. She stated not flushing with the prescribed amount of water could result in possible tube clogging. In an interview with the DON on 08/20/25 at 3:42 PM, he stated staff were to always to follow the doctors' orders on the amount of fluid to flush before and after medications. He stated failing to follow the orders could result in complications with the G-tube and discomfort to the resident. He stated not flushing with water could cause tube to clog. He stated all nurses were skills checked prior to G-tube medications administration and were expected to follow the physician ordered flushes. He stated any time a nurse questioned an order it was their responsibility to clarify the order. He stated they would be doing follow up monitoring to (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure staff were following proper procedures. Record review of the facility's policy, Irrigating a Feeding Tube, revised 04/22/2020, reflected, .Flush medication completely through the tube. Irrigate routinely before, between, and after final medication .

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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** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 (Resident #42) residents reviewed for respiratory care. The facility failed to ensure Resident #42's oxygen was administered at the correct setting of 2 liters per minute on 8/19/25 as ordered by the physician. The deficient practice could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. Record review of Resident #42's admission record dated 8/21/25 reflected an [AGE] year-old male with an admission date of 7/6/23. Pertinent diagnoses included seasonal allergic rhinitis (inflammation of sinus) and chronic obstructive pulmonary disease (constriction of the airways and difficulty or discomfort in breathing. Record review of Resident #42's Quarterly MDS assessment, dated 7/18/25 reflected resident's cognition was moderately impaired with a BIMS score of 9. Record review of Resident #42's order dated 7/21/25, reflected O2 (oxygen) @ 2 liters per minute by Nasal Cannula every shift [Time: Shift1, Shift 2, Shift 3] via Nasal Cannula for J44.1 Chronic obstructive pulmonary disease with (acute) exacerbationRecord review of Resident #42's person-centered care plan, reviewed on 4/2/25 reflected .Breathing Patterns [4/28/25: Reviewed and continue] Related to: DX of COPD [1/26/24: Onset](jc142)[4/28/25:Reviewd and Continue](lw156) Evidence by:.Oxygen 2 liter per minute inhalation every shift [9/26/24:Onset](mt204)[4/28/25:Reviewed and Continue.Record review of Resident #42's Medication Record dated 8/1/25 - 8/31/205 reflected 7/21/25 O2 @ 2LPM by NC continuous every shift.Observation of Resident #42 in his room in his wheelchair on 08/19/2025 at 10:13 AM with oxygen on via nasal cannula. The concentrator rate was set at 4 liters per minute (LPM) . Observation of Resident #42 on 08/20/2025 at 8:48 AM revealed resident was in his wheelchair asleep. He had O2 on via nasal cannula. The O2 level on the concentrator was 4 liters per minute. Observation and interview with RN A in Resident #42's room on 8/20/25 at 9:09am revealed RN A was Resident #42's nurse. RN A was asked to read the concentrator and without looking at it he stated it should be at 2 liters per minute. He was asked to read the concentrator, and he read it out loud and stated it as at 4 liters per minute. He then stated they must have changed Resident #42's order for oxygen because he had pneumonia last week. RN A stated he would verify the orders. He verified the orders and stated he could not find an order for 4 liters per minute and would clarify the order with the doctor. RN A stated Resident #42 had been needing more than 2 liters per minute of oxygen but there should have been a new order entered. He stated the oxygen was already on when he arrived on shift, as the resident needed continuous oxygen. RN A stated he should have checked resident's concentrator at least once every shift. If a resident got too much oxygen, the risk would be hyperventilation and false saturation which could cause more breathing issues. Interview with LVN B on 8/20/25 at 1:53pm revealed when residents were on continuous oxygen, they should be checking the concentrator every shift to ensure the resident had gotten the correct amount of oxygen as ordered by the physician. LVN B stated the risk to residents of not giving the right amount of oxygen was the resident would not have gotten the proper amount of oxygen as ordered by the physician. Interview with ADON F on 8/20/25 at 2:50pm revealed when nurses administered oxygen, they needed to have an order and when the oxygen was administered, they needed to make sure it was as ordered. ADON F when a resident was on continuous oxygen the expectation was the concentrator be checked every shift. The risk to the resident of receiving too much oxygen was it could cause adverse reaction and put too much stress on the lungs. She stated she did not know when Resident #42's oxygen was moved from 2 liters per minute to 4 liters per minute, but ADON F believed his oxygen needs changed recently. Interview with the DON on 8/20/25 at 3:23 pm revealed if a resident had a need for oxygen, then the staff needed to follow the doctor's (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order. The DON stated the nurses were expected to complete rounds and check the concentrator to make sure resident were receiving oxygen as ordered. The DON stated if a resident had gotten too much oxygen, it could exacerbate any type of lung issues the resident already had. Interview with LVN C on 8/20/25 at 3:41 pm revealed she had been working at the facility for 2 weeks. She stated Resident #42 received oxygen and she checked his concentrator every shift. She stated Resident #42's oxygen had not been matching the physician order due him having problems breathing. LVN C to her knowledge nurses could titrate oxygen up to 5 liters per minute without an order. She stated she was unsure if this was the facility policy, but it was the law. LVN C stated Resident #42 had pneumonia and they were having issues keeping his oxygen levels up. LVN C stated she thought they notified his Hospice when the oxygen was titrated. LVN C stated from her experience a new order should have been requested when the resident needed more than 5 liters per minute. LVN C stated she didn't know who initially titrated his oxygen, but she checked his O2 levels each shift to make sure 4 liters per minute was sustainable for him. LVN C stated she had never changed his level as he had been at 4 liters per minute since she started. Interview with ADON G on 8/20/25 at 3:54pm revealed the expectation at the facility was the nurses needed an order to titrate oxygen, they could only titrate without an order if it was an emergency, and the physician would have to be notified immediately after. ADON G the risk to the resident of having more oxygen then ordered would be it could cause the resident more complications. ADON G stated the nurses needed to follow oxygen orders as written. Review of the facility's policy Oxygen Therapy, Concentrator - Initiation revised 1/12/2020 reflected Standard of Practice: The licensed staff will provide the prescribed amount of oxygen therapy to the residents as prescribed by physician and according to practice guidelines.Procedure: 1. Review physician's orders for oxygen.9. Turn liter flow to the prescribed amount.Review of the facility's policy Physician Orders - Electronic revised 1/12/2020 reflected .2. The licensed nursing staff will provide residents with medications and treatments as ordered by his/her physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (200 Hall Nurses Cart) of 4 medication carts reviewed for pharmacy services in that:The facility failed to ensure 200 Hall Nurses Cart did not have 1 insulin pen for Resident #67 with an expired open date on [DATE]. This failure could affect residents resulting in diminished effectiveness and not receiving the therapeutic benefits of the medications.Record review and observation on [DATE] at 9:27 AM of the 200 Hall Nurses Cart, with LVN I revealed: The pen of insulin Lantus 100 unit/ml for Resident #44 with an expired open date of [DATE]. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use. Interview on [DATE] at 9:45 AM, LVN I stated nurses were responsible to check the medication carts and the insulin pens for the open dates before giving insulin. She stated the insulin was good for 28 days only after opened, after 28 days the insulin should be discarded because its effectiveness decreased. Interview on [DATE] at 3:42 PM, the DON stated the insulin flex pens and vials, once opened, needed to be dated because each insulin pen and vial had a specific day's shelf life and if not thrown out by that time the insulin could lose its effectiveness. The DON stated the pharmacy consultant checked the carts monthly and he stated he would do random checks of the medication carts for monitoring.Record review of the facility's policy titled Medication Storage, dated [DATE], reflected . Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the attending physician documented in the resident's medical record that the identified drug irregularity had been reviewed and what, if any, action had been taken to address it. If there was to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record for 1 of 6 Residents (Resident #66) whose psychotropic medications were reviewed.Resident #66's attending physician failed to address the pharmacist's recommendation to consider a gradual dose reduction. Resident #66 had been receiving Citalopram (antidepressant) 20 mg and Risperidone once a day every day since October 2024 and Alprazolam .25 mg twice a day everyday since October 2024.This deficient practice could contribute to Residents receiving a higher medication dose than necessary and result in adverse side effects.The findings included: Record review of Resident #66 Quarterly MDS assessment, dated 07/20/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (loss of cognition), anxiety (feelings of intense worry), and depression (feelings of sadness/loss of interest). Review of Section N- Medications- N0415. High-Risk Drug Classes- reflected she was taking antipsychotic, antianxiety, and an antidepressant. N0450. Antipsychotic Medication Review reflected the resident received antipsychotic medications on a routine basis, a Gradual Dose Reduction (GDR) had not been attempted, and the physician had not documented the GDR as clinical contraindicated. Record review of Resident #66's care plan, printed 08/19/25, reflected she received anti-anxiety medication of Alprazolam .25 mg by mouth two times per day and interventions included administer medication as ordered, ask physician to review medication for possible dose reduction every 3 months, and monitor behaviors every shift and side effects, dated onset of 10/07/24 and reviewed and continued 05/06/25. She received an antidepressant medication of citalopram 20 mg tablet by mouth once per day and interventions of administer medications as ordered, monitor for worsening of depression, monitor duration-prior to discontinuation may need a gradual dose reduction or tapering to avoid a withdrawal syndrome, dated onset of 10/07/24 and reviewed and continued 05/06/25. She received the psychotropic medication risperidone .25 mg one tablet by mouth once per day and interventions included monitor for side effects and behavior every shift, and physician to review medication for possible dose reduction, dated onset of 10/07/24 and reviewed and continued 05/06/25.Record review of Resident #66's physician orders reflected an order for: Citalopram 20 mg, one tablet for by mouth, once daily for Major depressive disorder, recurrent severe without psychotic features with a start date of 07/29/25. Alprazolam 0.25 mg tablet for Unspecified dementia, unspecified severity, without behavioral disturbance with a start date of 07/01/25 and discontinue date of 08/01/2025 and new start date of 08/01/25. Risperdal 0.5 mg tablet for Unspecified dementia, unspecified severity, without behavioral disturbance, administer 1/2 tablet 0.25 mg by mouth daily, with a start date of 07/18/25Record review of Resident #66's Medication Administration Record for the month of August 2025 (08/01/25-08/19/25) reflected she was monitored for behaviors regarding depression and side effects for antianxiety, antidepressant, and antipsychotic medications every shift. Record review of the Pharmacist's Medication Regimen Review Recommendations with documented outcomes between 06/01/25 and 06/18/25 reflected Resident has been taking the anxiolytic ALPRAZOLAM .25 BID since 10/24 Please evaluate the current does and consider a dose reduction . With an outcome/response of declined without rationale. Review of Resident #66's progress notes from May 2025 to August 2025 did not reveal documentation which addressed the Consultant Pharmacist review, dated 05/11/25 or 06/18/25.In an interview on 08/21/25 at 12:38 PM with the DON, he stated he was responsible for reviewing the Medication Regimen Review (MRR) recommendations and ensuring the originals were signed by the physician with a response. He stated that he had recently (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	starting working at the facility about 3 months ago, and had not noticed there was an issue with the MRR responses. He stated that usually the next step was a psychiatric assessment and then it was determined if a GDR should be attempted. He stated that Resident #66 had not received a GDR and was on the medications risperidone, alprazolam, and citalopram since she transferred from another facility in October of 2024. He stated that his expectation was that GDR trials were attempted unless it was contraindicated. He stated that GDRs were important because they could impact a resident's cognition and possibly could be on a medication that was not needed. He stated that moving forward, the facility would have interdisciplinary meetings with the Medical Director to review the residents on medications and GDR recommendations. In an interview on 08/21/25 at 1:24 PM with the Medical Director, he stated he was Resident #66's physician for many years before she admitted to the facility in October of 2024. He stated that he visited the facility multiple days per week and any GDR recommendations were reviewed and he submitted his response to the facility by signing the physician response form. He stated he could not recall the most recent MRR recommendations and was not in front of his computer to review the resident's chart. He stated when a GDR was recommended by the pharmacist, he typically reduced medications by 25% and monitored the resident for any indication that a GDR was contraindicated. He stated that Resident #66 was on a low dose of risperidone, alprazolam, and citalopram, and had been on the medications since she admitted to the facility, so there was a low risk to the resident and no impact on morbidity for not having a GDR attempt. In an interview on 08/21/25 at 2:57 PM with ADON L, she stated she was aware Resident #66 received psychotropic, antidepressant, and antianxiety medications and there were no concerns with over medication and stated Resident #66 had been stable since admitting to the facility. She stated she was responsible for reviewing the pharmacy consultant recommendations with the DON during plan of care meetings and was not aware there was a concern with the MRR recommendations not receiving a response. She stated she had only been ADON for the past 2 weeks and was going to be involved and address the issue. She stated gradual dose reductions were important to ensure residents were not on unnecessary medications. In an interview on 08/21/25 at 2:02 PM with the Pharmacy Consultant he stated that declined without rationale meant he never received a response from the physician regarding the MRR recommendations, and would have to look at his notes to refresh his memory. He stated that the facility had several changes of the DON and the ADON and had planned to discuss the non-response during his next visit to the facility.Record review of the facility's Medication Monitoring policy titled, Medication Regimen Review and Reporting, dated January of 2024, reflected .Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. In accordance with state regulations, the consultant pharmacist or clinical pharmacist at the provider pharmacy works with the nursing care center nursing staff to gather pertinent information related to the resident's status and/or request for consultation.Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician.Medication Monitoring Medication Management.New Admissions: The attending physician in collaboration with the consultant pharmacist must re-evaluate the use of the psychotropic medication and consider whether or not the medication and be reduced or discontinued upon admission or soon after admission. Additionally, the facility is responsible for: . Obtaining physician orders for the resident's immediate care.Record review of the facility's psychotropic drugs policy titled, Psychotropic Drugs-Use, dated revised July 27, 2022 reflected: Purpose: 1. The community will use psychotropic drug therapy when appropriate to enhance the quality of life, while maximizing functional potential and well-being of the patient/resident. For drug therapy: Within the first year in which a resident is admitted on a psychotropic medication or after the facility has initiated a psychotropic medication: GDR attempts in two separate quarters with at least one month between the attempts. The GDR must be attempted annually thereafter unless clinically contraindicated.

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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 designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 (Resident #10, Resident #56, and Resident #61) of 5 residents reviewed for infection control. The facility failed to ensure MA N disinfected the blood pressure cuff in between blood pressure checks for Residents #10, Resident #56, and Resident #61. This failure could place residents at-risk of cross contamination which could result in infections or illness. 1.Record review of Resident #10's Quarterly MDS assessment, dated 07/25/25, reflected Resident #10 was a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included elevated blood pressure, multidrug-resistant organism (microorganisms that are resistant to at least one class of antimicrobial agents, including antibiotics, and wound infection). Resident #3 had a BIMS of 3 which indicated Resident #10's cognition was severely impaired. Record review of Resident #56's Quarterly MDS assessment dated [DATE] reflected Resident #56 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebrovascular accident (a condition that occurs when blood flow to the brain is blocked. The blockage can lead to brain tissue death.), and elevated blood pressure. Resident #56's BIMS score of 14, indicated Resident #56' cognition was intact. Record review of Resident #61's Quarterly MDS assessment, dated 06/16/25, reflected Resident #61 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included elevated blood pressure and type 2 diabetes mellitus. Resident #61's BIMS score of 11, indicated Resident #61's cognition was moderately impaired. Observation on 08/20/25 at 7:58 AM revealed MA N performing morning medication pass, during which time she checked the blood pressure on Resident #10. MA N did not sanitize the blood pressure cuff before and after using it on Resident #10 and continued to the next resident without sanitizing the blood pressure cuff. MA N then checked Resident #56's blood pressure. MA N did not sanitize the blood pressure cuff before using it on Resident #56. She continued to the next resident without sanitizing the blood pressure cuff. MA N then checked Resident #61's blood pressure. MA N did not sanitize the blood pressure cuff before using it on Resident #61. Interview on 08/20/25 at 8:40 AM, MA N 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.In an interview with the DON on 08/20/25 at 3/42 PM, he stated his expectation was for staff to sanitize the blood pressure cuff after each use. He stated to ensure staff were knowledgeable in the sanitation of the blood pressure cuff the facility would do skills competency checks and he stated he would make daily rounds and watched care and medication administration. Record review of the facility's policy titled Disinfecting and Sterilizing Resident Care Equipment, revised March 2025, reflected . Non-critical items are those that either do not ordinarily touch the residents or touch only intact skin. Such items include . blood pressure cuffs . it is imperative that these items are clean.

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	08/21/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident bedside and toilet and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 3 of 23 residents (Resident#13, Resident#30, Resident #4) reviewed for resident call system. 1) The facility failed on 08/19/2025 to ensure the call light system was adequately equipped, the call light string was lying on the floor in the shared resident toilets located inside the resident rooms.2) The facility failed to ensure the call light device was within the reach of Resident #4 on 08/19/2025 when the resident was lying in bed in his room. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for activities of daily living.1) Record review of Resident #13's face sheet dated 08/21/2025 reflected she was a [AGE] year-old female with an original admission date of 07/18/2025. Record review of Resident #30's MDS dated [DATE] reflected he was an [AGE] year-old male with an admission date of 07/30/2025, BIMS sore of 09 indicated moderate cognitive impairment. His diagnoses included Chronic Obstructive Pulmonary Disease (breathing difficulty). Review revealed Resident #30 required partial to moderate assistance with ADLs. Observation on 08/19/2025 at 10:01 AM inside Resident #13's shared bathroom revealed the call light device string was lying on the floor. Interview with Resident #13 revealed she needed assistance with ADLs. Observation on 08/19/2025 at 01:12 PM inside Resident #30's shared bathroom revealed the call light device string was lying on the floor. An interview and observation on 08/19/2025 at 02:23 PM with the Maintenance Director at both Resident #13 and #30's bathroom, he looked at the call light string and stated the call light string was expected to stay above the floor, and he was responsible to repair and maintain the call light system. He stated the call light string lying on the floor increased the risk for call light device malfunction and he expected all the employees to notify him when they saw the string was lying on the floor. He stated all the employees regularly received in-service trainings on call light device and he would right away repair the call light device on both rooms. An interview on 08/19/2025 at 02:05 PM with LVN Q revealed it was the Maintenance Director's responsibility to repair, maintain and ensure the call light system was adequately equipped, and all the employees were responsible to let the Maintenance Director know that the call light string was lying on the floor. He stated the call light string was expected to stay above the floor and lying on the floor could affect the proper functioning of the device. He stated he and his employees regularly received in-services on call light devices. An interview on 08/19/2025 at 01:47 PM with RN R revealed it was the maintenance director's responsibility to repair, maintain and ensure the call light system was adequately equipped. RN R stated all the employees were responsible to let the maintenance director know that the call light string was lying on the floor. He stated the call light string was expected to stay above the floor and lying on the floor could affect the proper functioning of the device. He stated he and his employees regularly received in-services on call light devices. An interview on 08/19/2025 at 02:22 PM with CNA S revealed the Maintenance Director was responsible to repair, maintain and ensure the call light system was adequately equipped. CNA S stated all the employees were responsible to let the maintenance director know that the call light string was lying on the floor. He stated the call light string was expected to stay above the floor and lying on the floor could affect the proper functioning of the device. He stated he received an in-service on call lights within the past month. An interview on 08/19/2025 at 03:35 PM with DON revealed he expected the Maintenance Director to repair, maintain and ensure the call light system was adequately equipped and working properly. The DON stated all the employees were responsible to let the Maintenance Director know that the call light string was lying on the floor. He stated the call light string was expected to stay above the floor and lying on the floor could affect the proper functioning of the device. Th DON stated all the employees received an (continued on next page)

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	676349	A. Building B. Wing	08/21/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-service on call lights within the past month. 2) Record review of Resident #4 MDS assessment, dated 07/18/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of cancer, dementia (loss of cognition), quadriplegia, and had moderately intact cognition. Record review of Resident #4 care plan, printed 08/19/25, reflected he had impaired physical mobility and was a fall risk due to quadriplegia, dated 06/24/25. Interventions included keep call light within reach and provide appropriate level of assistance to promote safety of the resident. Observation on 08/19/25 at 9:32 AM revealed CNA H exited Resident #4's room with his breakfast tray. In an observation and interview on 08/19/25 at 9:34 AM revealed Resident #4 was laying in bed and his call light was on the floor next to his bed. Resident #4 stated that he needed his call light and was not sure where it was located. In an observation and interview on 08/19/25 at 9:43 AM with CNA H, she stated she had picked up Resident #4's tray and did not notice that the call light was on the floor before she left his room with his breakfast tray. CNA H picked up the call light and clipped it to Resident #4 blanket within reach. CNA H stated she should have checked before leaving Resident #4 room and ensured his call light was within reach. She stated that it was important to ensure a resident's call light was within reach because the resident may need to ask for help. In an interview on 08/19/25 at 1:04 PM with LVN I, she stated CNA H should have ensured Resident #4's call light was within reach before leaving his room. LVN I stated it was important to ensure resident call lights were always within reach so the residents could call for assistance. In an interview on 08/21/2025 at 2:57 PM with ADON L, she stated Resident #4's call light was supposed to always be within reach residents. She stated before staff left the resident's room, they should have ensured the call light was within reach. She stated it was important for resident call lights to be within reach because that was how they called for help; it was their life line.In an interview on 08/21/25 at 12:38 PM with the DON, he stated his expectation was for staff to ensure resident call lights were within reach before leaving the room. He stated having the call light within reach of the resident was important for residents to be able to call for assistance if there was an emergency.Record review of facility policy titled call lights answering with reviewed date of 01/19/2023 reflected: Purpose: Policy: .The staff will provide an environment that helps meet the resident's needs by answering call lights appropriately. when leaving the room, be sure the call light is placed within the resident's reach .