STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676437	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at College Station	1500 Medical Avenue College Station, TX 77845

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** 49099 Based on observation, interview, and record review the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 6 residents (Resident #1) reviewed for physical environment. The facility failed to ensure Resident #1 had a working call light in their room. This failure could place residents at risk of not being able to get assistance when needed. Findings include: Record review of Resident #1's face sheet dated 08/23/24 reflected a [AGE] year old male who was admitted to the facility on [DATE] with a diagnoses that included heart failure, chronic atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to stroke, heart failure, and other complication), benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of the prostate gland) with lower urinary tract symptoms, muscle weakness, difficulty walking, and essential (primary) hypertension (high blood pressure). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 10 which indicated mild cognitive impairment. Section GG of the MDS which covered functional abilities reflected Resident #1 required supervision or touching assistance with toileting, shower/ tub transfers, and chair to bed transfers. Section H of the MDS reflected Resident #1 was occasionally incontinent of bowel and urinary continence. Record review of Resident #1's care plan revised 03/29/24 reflected a problem identified of [Resident #1] is a moderate risk for falls deconditioning, gait/balance problems with interventions that included, the resident needs a safe environment; even floors free from spills and/or clutter, adequate glare free light, a working and reachable call light . Another problem identified in the care plan was, [Resident #1] has an ADL self-care performance deficit with interventions that reflected resident required x1 staff participation with toilet use, transfers, and bed mobility and stated, encourage the resident to use bell to call for assistance. Record review of Resident #1's nursing progress notes dated 07/23/24 reflected Resident #1 was moved to his current room on 07/23/24 and his RP was notified of the room change and approved. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility fall incidents generated 08/23/24 revealed Resident #1 did not have a fall between 05/23/24 and 08/23/24. An observation and interview on 08/23/24 at 10:55 AM revealed Resident #1 sitting in his wheelchair at bedside, Resident #1 stated that his call light has not worked for him since moving into that room from another room in the facility. Resident #1 stated when he needed assistance if he was in his chair, he would try to propel himself into the hall to get someone's attention and he said if he was in bed the only way he can get help was if he screamed. Resident #1 stated he wanted his call light fixed because it bothered him and did not make him feel good that he couldn't call for help when he needed it. Resident #1 stated he had not suffered any injuries from falling due to not being able to use his call light. He stated he had notified an employee previously about the concern, but nothing was done about it. Resident #1 was not able to provide the name of the employee he notified because he stated he did not remember. An observation was made of Resident #1 pushing his call light and neither the indicator light at the base of the call light nor the light outside of the room were activated. An observation made of the call light base on the wall revealed the plastic base plate was broken off and detached exposing a red and white wire which were detached from the inside. An additional observation revealed a sign posted on the wall directly in front of the resident's bed which reflected, call don't fall indicating the resident was a fall risk. An observation and interview on 08/23/24 at 11:04 AM with LVN A, she was observed attempting to push the call light which did not activate the light at the base connected to the wall or outside of the room. LVN A was observed touching the wall base to which she then said, Oh it fell apart. The call light base along with the call light cords were then observed to have completely fallen off the wall. LVN A stated she did not know how long the call light had been nonfunctional but that it was important Resident #1 had a functioning call light. LVN A stated that a potential negative outcome would be the resident could be in pain with no way to call for help or could fall. LVN A stated she would immediately let the MNT know of the issue and that Resident #1 would be given a bell to use in the meantime. An observation on 08/23/24 at 11:15 AM the MNT was observed in Resident #1's room fixing the call light. LVN A was observed checking other residents' rooms for call light functionality. Observations of other residents' rooms at this time did not reveal other call light issues/ concerns. An interview on 08/23/24 at 01:28 PM with CNA B, she said call lights were supposed to be functional and answered in a timely manner which she said was within 10 minutes. CNA B said she checked for call light placement and functionality anytime she is in a resident's room or when a resident verbalizes that there was an issue with the light. She stated that any problems with call lights were reported immediately to the MNT, and he worked on them pretty quick. CNA B said that a potential negative outcome to a nonfunctioning call light would be the resident could end up on the floor. An interview on 08/23/24 at 01:37 PM with MA C, she stated that she checked call light placement and functional status anytime she was in the room for care or medication pass. MA C said she was not aware of any call light issues currently with any residents. She stated a nonfunctional call light was an issue and said, that was why they are there for residents to get assistance. If they fall, they need to be able to contact someone for help. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/23/24 at 02:05 PM with the MNT, he stated that there was a system staff report any maintenance issues through and if it is something serious like a call light issue, he worked on it immediately. He stated he was also on call on the weekends for issues that arise. The MNT said that residents were supposed to be provided a hand bell in the meantime while the call light issue was resolved. He stated that the call light in Resident #1's room for his side of the bed (bed A) was not able to get repaired and they moved Resident #1 temporarily to bed B which was able to get repaired since he was the only resident in that room. The MNT said he reached out to the company that diagnosis and fixed the call light system, and they would be in the following week for repairs. He stated the call light was in fact not initially transmitting a signal at all to the nurse's station for side A. After fixing and reattaching the plate and cords to the wall, side B was now transmitting a signal, but side A was still not which was why it needed to be looked at by the company he scheduled. The MNT said that there was not a previously reported maintenance concern for Resident #1's call light in his maintenance logs. He stated other call lights were checked and in working order. An interview on 08/23/24 at 02:22 PM with the DON she stated that it was her expectation that resident call lights were always within reach and functional whether they are in their wheelchair at bedside or in bed. She stated if there is a call light that was not functioning staff are to notify maintenance immediately and get the resident a hand bell they can use to call for help until the problem was resolved. The DON stated that residents call lights were checked in the mornings during angel rounds, and they assess for placement and functionality. She stated these rounds are conducted by heads of departments. The DON said that a potential negative outcome to a nonfunctional call light is a resident could fall trying to reach for something or could be choking and need to call for assistance. She stated that sometimes residents also call when their neighbor needs help or is doing something unsafe. An interview on 08/23/24 at 02:41 PM with the ADON she stated it was her expectation that call lights are in reach, functional, and answered in a timely manner. She stated that it is all staff's responsibility to answer them in a timely manner. She said if one was not functional the resident would need to be provided with a bell until it is fixed or would need to be moved into a new room if it was not able to get fixed. The ADON said that the MNT is on call even when he is out of the building and can come in if there is an emergency and a call light needs to be fixed. She said a potential negative outcome to a nonfunctional call light was nobody would know what the residents' needs were and they wouldn't be able to call for help. The ADON said that she was not made aware of the call light problem in Resident #1's room previously and it was not something they caught or were notified about. An interview on 08/23/24 at 03:09 PM with the ADM he stated that it was his expectation that call lights were always in proximity and never away from the resident to where they don't have access to it. He stated they should also be functional. The ADM said if the call light went down the residents should be given a hand bell or a whistle so they can call for help. He stated that not being able to call for help could prevent residents from getting help with pain or other needs. The ADM said, It is a customer service issue as well as a clinical issue. He stated that maintenance does routine checks on the call lights as well as angel rounds checks by other staff. Record review of the facility maintenance logs revealed there was not a previously reported call light maintenance request from 07/23/24 through 08/23/24 from Resident #1's room. Review of the facility policy Answering the call light last revised 10/2010 reflected: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Be sure the call light is plugged in at all times. - Report all defective call lights to the nurse supervisor promptly. - Answer the residents call as soon as possible.