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	01/09/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on interview and record review the facility failed to establish a grievance policy to ensure the prompt resolution of all grievances regarding the resident rights and maintain evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision for 1 of 7 residents (Resident #1) reviewed for grievances. The facility failed to resolve grievances filed between 11/13/24 and 12/06/24 by the FM for Resident #1 or to maintain copies of the grievances and their resolutions. This failure could place residents at risk of not having their grievances resolved. Findings include: Record review of Resident #1's, undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included metabolic encephalopathy (a change in how the brain works due to an underlying condition), spinal stenosis (narrowing of spaces in the spine causing pain, numbness, and tingling), hypertensive urgency (marked elevation in blood pressure without evidence of target organ damage), dementia , hyperlipidemia (high cholesterol), syringomyelia and syringobulbia (conditions causing fluid-filled cavities on the brain stem and spinal cord). Record review of Resident #1's care plan, dated 11/05/24, reflected the following: [Resident #1] has impaired thought processes. Will improve decision making ability by next review date. Discuss concerns about confusion, disease process, NH placement with the resident/family/caregivers. Record review of Resident #1's discharge MDS, dated [DATE] , reflected a BIMS score of 00, which indicated severely impaired cognition. Record review of grievances from October 2024 to January 2025 provided by the ADM reflected no grievances related to Resident #1. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 10:14 AM, the FM for Resident #1 stated he filed at least three grievances related to Resident #1's care, and he never heard anything back on the result of the grievances. He stated he had tried to give the grievances to the DON, and she gave them all back at once and told him he needed to give them to the administrator at the time. The FM stated the administrator was not in the building at that time, so the FM put the grievances under the administrator's door. He stated he thought this was the last week of November 2024 but could not remember the exact dates on the grievances. During an interview on 01/09/25 at 02:00 PM, the DON stated she remembered there were some grievances related to Resident #1 and she had a lot of communication with Resident #1's FM, but she could not remember the exact content of the grievances and did not know what had happened to them. She stated she started as the DON at the end of October 2024 and was still learning the job while Resident #1 was in the facility, but she communicated frequently with Resident #1's FM and did her best to resolve any issues brought to her attention . During an interview on 01/09/25 at 04:31 PM, the ADM stated she looked in all the management offices and was not able to find the grievances filed by Resident #1's FM in November 2024. She stated she had just taken the position as administrator on 12/16/24 and had not known Resident #1 or her FM . She stated she was not able to contact the previous administrator. She stated she was the person responsible for the written grievance process, and she monitored that process by following up on every single grievance to ensure they were resolved. She stated if a grievance was made and not written and filed, it could keep interventions from being implemented, which could have a negative impact on almost every area of resident life. Record review of the facility's policy, dated August 2008, and titled Filing Grievances/Complaints reflected the following: Our facility will help residents, their representatives, other interested family members, or resident advocates file grievances, or complaints when such requests are made without discrimination or reprisal, and without fear of discrimination or reprisal . 5. Upon receipt of a grievance and/or complaint, the designated staff member will investigate or delegate the investigation accordingly to the responsible department head, who will investigate the allegations and submit a written report of such findings to the administrator within five working days of receiving the grievance and/or complaint. The designated grievance official will oversee the grievance process, receiving and tracking grievances to ensure corrective action if needed. 6. The administrator will review the findings with the person investigating the complaint to determine what corrective actions if any need to be taken. 7. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation, and the actions that will be taken to correct any identified problems. The administrator, or his or her designee, will make such reports orally within five working days of the filing of the grievance or complaint with the facility. A written summary of the investigation will also be provided to the resident upon request, and a copy will be filed in the social service office or the administrator's office.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38073 Based on observation, interview and resident review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 10 residents (Residents #1, #2 and #3) reviewed for ADL care. The facility failed to ensure Residents #1, #2 and #3 received baths or showers as scheduled. This failure could place residents at risk of embarrassment and unidentified skin issues . Findings include: 1. Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included metabolic encephalopathy (a change in how the brain works due to an underlying condition), spinal stenosis (narrowing of spaces in the spine causing pain, numbness, and tingling), hypertensive urgency (marked elevation in blood pressure without evidence of target organ damage), dementia , hyperlipidemia (high cholesterol), syringomyelia and syringobulbia (conditions causing fluid-filled cavities on the brain stem and spinal cord). It reflected she discharged for m the facility on 12/06/24. Record review of Resident #1's discharge MDS, dated [DATE], reflected she was totally dependent on staff for bathing. It reflected a BIMS score of 00, which indicated severely impaired cognition. Record review of Resident #1's care plan, dated 11/05/24, reflected the following: [Resident #1] has an ADL Self Care. Will maintain current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. Performance Deficit Bathing: [Resident #1] requires (X 1-2) staff participation with bathing. Record review of the, undated, shower schedule reflected the room Resident #1 occupied from 10/22/24 to 12/06/24 was scheduled for a shower on Tuesday/Thursday/Saturday. Record review of showers documented for Resident #1 during her stay at the facility from 10/11/24-12/06/24 reflected she was provided the following showers: 10/18/24 10/23/24 10/27/24 11/07/24 11/09/24 11/19/24 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/24/24 12/02/24 12/06/24 Showers were scheduled but not documented as given on 10/15/24 10/20/24 10/29/24 10/31/24 11/02/24 11/05/24 11/12/24 11/14/24 11/16/24 11/21/24 11/26/24 11/28/24 11/30/24 2. Record review of Resident #2's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included cerebral infarction (pathologic process that results in an area of dead tissue in the brain), gram-negative sepsis (a condition where gram-negative bacteria cause sepsis, which is a life-threatening condition that occurs when the body's response to an infection damages its own tissues and organs) , hypotension (low blood pressure), hypertension (high blood pressure), arthritis of knee, hypothyroidism (low thyroid hormone), kidney failure, aphasia (A comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain .), syncope and collapse (fainting or passing out), bipolar disorder, social phobia, and insomnia. Record review of Resident #2's admission MDS dated [DATE] reflected she was totally dependent on staff for bathing and required partial/moderate assistance for bed moving in her bed. It reflected she had one stage III pressure ulcer upon discharge. It reflected a BIMS score of 00, which indicated severely impaired cognition. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan dated 01/08/25, reflected the following: [Resident #2] has an ADL Self Care. Will maintain current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. Performance Deficit Bathing: [Resident #2] requires (X 1) staff participation with bathing. Record review of the shower schedule reflected Resident #2 was scheduled for showers on Tuesdays, Thursdays, and Saturdays during the day shift. Record review of showers recorded for Resident #2 between 12/21/24 and 01/09/25 reflected she was provided the following showers: 12/24/24 12/26/24 12/28/24 12/31/24 01/04/25 Showers were scheduled but not documented as given on 01/02/25 01/07/25 During an interview on 01/09/25 at 11:43 AM, LVN A stated she was the charge nurse over her CNAs and she made sure showers were done and refusals documented. She stated she monitored for compliance by going into the resident rooms and asking if they were showered. LVN A stated she did not know Resident #2 had not received all of her showers. LVN A stated some of those showers were supposed to happen on her days off, and CNA B was responsible for the last few showers. She stated Resident #2 needed to have her showers regularly in order to be clean and not risk infection. She stated she was not aware of Resident #2 having any refusals. During observation and interview on 01/09/25 at 11:50 AM, revealed Resident #2 was sitting in her wheelchair in her room. She was conversant but could not answer questions easily. Her hair was slightly disheveled and greasy. She did not answer when asked about showers. 3. Record review of Resident #3's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included atrial fibrillation (an irregular and often very rapid heart rhythm), morbid obesity due to excess calories, asthma, type two diabetes mellitus , chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs, resulting in inflammation and swelling inside the airways), mild dementia, generalized anxiety disorder , and visual disturbance (anything that impacts the ability to see clearly and comfortably). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's quarterly MDS dated [DATE] reflected she was totally dependent on staff for bathing. It reflected she had one stage III pressure ulcer upon discharge. It reflected a BIMS score of 15, which indicated intact cognition. Record review of Resident #3's care plan, dated 10/03/24, reflected the following: [Resident #3] has an ADL Self Care. Will maintain current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. Performance Deficit Bathing: [Resident #3] requires (X 1) staff participation with bathing. Record review of the shower schedule reflected Resident #3 was scheduled for showers on Tuesdays, Thursdays, and Saturdays during the day shift. Record review of showers recorded for Resident #3 between 12/11/24 and 01/09/25 reflected she was provided the following showers: 12/12/24 12/14/24 12/21/24 12/28/24 01/02/25 01/07/25 Showers were scheduled but not documented as given on 12/17/24 12/19/24 12/24/24 12/26/24 12/31/24 01/04/25 Record review of grievances from October 2024 to January 2025 reflected a grievance filed by Resident #3 on 12/18/24 that contained the following information: Resident reports she has not had a shower since Thanksgiving. Requests shower. The resolution reflected the following: Resident received shower. Refuses at times- documented. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 01/09/25 at 12:10 PM, Resident #3 was in her room. She was clean and groomed. She stated she missed many showers, as the CNAs were often telling her they did not have time. She stated she did not think she had ever refused. She stated the new administrator said it would get better, but they were still not doing the showers according to schedule. She stated she received her last scheduled shower . She stated she felt embarrassed and uncomfortable when she did not get her showers. During an interview on 01/09/25 at 12:20 PM, CNA C stated she always gave showers when they were scheduled. She stated she gave Resident #3 a shower the day prior. She stated she did not know Resident #3 had not received her scheduled shower before that, and she had not been working that day on 01/04/25. A telephone interview was attempted on 01/09/25 at 12:45 PM with CNA B. A voicemail was left and not returned. During an interview on 01/09/25 at 02:00 PM, the DON stated the nursing staff were responsible for ensuring residents received their showers. She stated the CNAs should have documented any refusals and should never document Not Applicable. During an interview on 01/09/25 at 04:31 PM, the ADM stated the nursing department was responsible for ensuring showers were given as scheduled. She stated she had not developed a system to oversee and ensure compliance, because she was so new to the facility. She stated potential negative impacts of not receiving showers were poor hygiene, unidentified skin issues and infection . Record review of the facility policy, dated October 2009, and titled Shower/Tub Bath reflected the following The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed. 2. The name of the individual who assisted the resident with the shower/tub bath. 3. All assessment data obtained during the shower/tub bath. 4. If the resident refused the shower/tub bath, the reason reasons why, and the intervention taken. Reporting 1. Notify the supervisor if the resident refuses the shower/tub bath. 2. Notify the physician of any skin areas that may need to be treated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Report other information in accordance with facility policy and professional standards of practice.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 5 residents (Resident #1) reviewed for pressure ulcers. 1. The facility failed to reposition Resident #1 during the overnight shift on 11/25/24 after she developed a stage III pressure ulcer identified on 11/20/24. 2. The facility failed to refer Resident #1 to the RD after the WCD recommended a dietitian consult on 11/19/24. This failure could place residents at risk of worsening pressure ulcers. Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses included metabolic encephalopathy (a change in how the brain works due to an underlying condition), spinal stenosis (narrowing of spaces in the spine causing pain, numbness, and tingling), hypertensive urgency (marked elevation in blood pressure without evidence of target organ damage), dementia, hyperlipidemia (high cholesterol), syringomyelia and syringobulbia (conditions causing fluid-filled cavities on the brain stem and spinal cord). Record review of Resident #1's care plan, dated 11/21/24 , reflected the following: [Resident #1] has pressure injury Stage 3 Pressure Wound Sacrum with potential for further pressure injury development r/t Decrease mobility. Record review of Resident #1's discharge MDS, dated [DATE], reflected she required partial/moderate assistance for moving in her bed. It also reflected her number of Stage III pressure ulcers was one. It reflected a BIMS score of 00, which indicated severely impaired cognition. Record review of Resident #1's weekly skin assessments for reflected the following, documented by the TXN: 11/07/24 Open lesion sacrum 5.5 cm (width) x 11 cm (length) x 0.1 cm (depth) 11/12/24 Open lesion sacrum 3 cm x 4 cm x 0.1 cm 11/20/24 Pressure stage III sacrum 3.5 cm x 4.5 cm x 0.1 cm 11/26/24 Pressure stage III sacrum 1.2 cm x 0.6 cm x 0.1 cm 12/03/24 Pressure stage III sacrum 1.6 cm x 0.8 cm x 0.1 cm Record review of wound care physician notes reflected the following notes: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/12/24 Goal of treatment is healing evidenced by a 80.2% decrease in surface area within the wound bed in comparison to the previous wound care visit. 11/19/24 Exacerbated due to generalized decline of patient, not offloading well. The progress of this wound and the context surrounding the progress were considered in greater detail today. Discussed pain and pain management strategies with patient, family, and/or care providing staff. Patient not following repositioning or off-loading recommendations and counseling provided. Impaired nutritional status discussed with patient, family, nursing staff, and/or dietitian. Reviewed off-loading surfaces and discussed surfaces care plan. Discussed signs of atypical ulceration and consideration of biopsy with patient and/or family. Considered patient behavior as factor that is complicating wound healing and discussed it further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Recommendations Off-Load Wound; Reposition per facility protocol; Turn side to side in bed every 1-2 hours if able; Low Air Loss Mattress. additional recommendations related to performed expanded evaluation Nutritional Status: Dietitian consult. 11/26/24 Improved evidenced by decreased surface area. 12/03/24 Exacerbated due to mattress on static, husband report little turning at night. Record review of a document for Resident #1, dated 12/09/24, and titled Evaluation of Clinically Unavoidable Pressure Injury reflected the following interventions in place: turn/reposition as indicated, offloading of extremities, pressure redistribution mattress, RD consult, vitamins and dietary supplements. It reflected the following clinical conditions that are primary risk factors for developing pressure ulcers were triggered: Immobility secondary to underlying disease process and incontinence of bowel and/or bladder. Observation of video footage from Resident #1's automated electronic monitoring reflected no person entered Resident #1's room from 09:00 PM to 04:45 AM on the night of 11/13/24 and the morning of 11/14/24. During an interview on 01/08/25 at 02:43 PM, the WCD stated Resident #1 was difficult to work with, because she would scream out anytime they tried to do anything with her. The WCD stated he could calm her down by speaking with her nd she would allow him to proceed without screaming. The WCD stated she initially had moisture-associated skin damage, and then his wound care company had him stage the wound to a stage III, because then they would be able to debride the wound. A lot of the reason the wound developed and worsened to the stage III was Resident #1's refusal to offload (take pressure off the wound). The WCD stated he was aware of the allegation that staff did not care for Resident #1 overnight, but he knew the ADONs had conducted an investigation and they assured him it was not an issue. He stated his experience with this clinical team was they told him if they failed instead of lying to cover it up, so he felt they were generally honest about their [NAME]. The WCD stated Resident #1's wound was clinically unavoidable due to her refusal to offload and her declining condition. He stated the recommendation of a dietitian consult was made as a last ditch effort, but anything the dietitian recommended would not have helped in the amount of time Resident #1 remained in the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/25 at 12:36 PM, the TXN stated Resident #1 did acquire a pressure ulcer at the facility, and they treated it, and it improved. The TXN stated Resident #1's FM was always concerned, and she always felt every concern was valid. The TXN stated the staff felt his wish they wake Resident #1 up every hour to reposition her and give her water was excessive, but the staff should have been repositioning her every two hours and checking to make sure she was dry. The TXN stated she was not sure if anyone went in Resident #1's room on the night shift, but she knew the nurses went in at night as well as the CNAs. She stated Resident #1 would scream as if in pain and refuse to be turned. The TXN stated Resident #1 was treated for pain, and they did all they could to try to alleviate her anxiety, but she just did not want to be moved all the time, and the FM did not seem to understand that it was her right to refuse. The TXN stated he also had an issue if the staff did not reposition every two hours on the dot rather than needing an extra five or ten minutes to get in to see her. The TXN stated they started her on supplements, and she had an air mattress, and the wound was improving steadily prior to her discharge. She stated she could not remember the physician's recommendation of a dietitian consult, but the RD would have been consulted automatically if she had stayed in the facility longer. During an interview on 01/09/25 at 01:27 PM, the RD stated a request for consult should have been made a day or two after the physician ordered or recommended it . She stated 16 days was too long to wait for the recommendation. She stated she did not know if she would have been able to make much of a difference when Resident #1 discharged on [DATE], but the referral should have been made. The RD stated she did not receive a request for a consult for Resident #1 after 11/19/24. She did see Resident #1 when she first admitted to the facility, and at the point there were several risk factors that she addressed. During an interview on 01/09/25 at 02:00 PM, the DON stated the facility policy was residents should have been checked on every two hours during the overnight shift and changed or repositioned as necessary. The DON stated the potential negative impact of not being repositioned every two hours depended on whether the resident was eating well, drinking well, and receiving the proper medications. She stated a referral for a dietitian consult should have been made by the TXN within one or two days of the physician recommending it. The DON stated she was not sure whether a referral was made to the dietitian, because Resident #1 discharged 16 days after the physician recommendation, The DON stated she did not necessarily monitor directly to ensure residents were being checked and repositioned every two hours, but the nurses monitored that. The DON stated Resident #1's FM was her advocate, and the FM would not have allowed her care to slip. During an interview on 01/09/25 at 04:31 PM, the ADM stated the TXN was the responsible person for the pressure ulcer prevention program. She stated she was new to the facility and had not developed a system to ensure the program facilitated compliance with regulations. She stated potential negative side effects of the failures to reposition and refer for a dietitian consult were infection, worsening skin conditions, sickness, debilitation, pain and indignity. Record review of the facility policy, dated July 2017, and titled Prevention of Pressure Ulcers/Injuries reflected the following: Purpose The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. (continued on next page)

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	01/09/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nutrition 1. Monitor the resident for weight loss and intake of food and fluids. 2. Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. Mobility/Repositioning 1. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences. 2. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort. 3. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions. Support Surfaces and Pressure Redistribution Select appropriate support surfaces based the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. Monitoring 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis.