

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Accel at College Station		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interview, and record review the facility failed to ensure the resident was free from neglect for one resident (Resident #1) of four residents reviewed for neglect. The nursing staff failed to assess or make any observations on Resident #1 after he was admitted to the facility 01/14/2025 at 5:47 PM until approximately 7:45 PM. Resident #1 was unable to assist self to the bathroom and urinated on himself and was in distress. This failure placed residents at risk of neglect, injury, and psychosocial harm. Findings included: Review of Resident #1's face sheet, dated 02/21/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's diagnoses was not listed on the face sheet. Review of the Resident #1's facility report reflected Resident #1's diagnosis was generalized weakness (a feeling of lacking physical strength throughout most of your body, where you feel you need to exert extra effort to move your muscles), COVID (a mild to severe respiratory illness) , Chronic Renal Failure (a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood), chronic heart failure (a weakened heart condition that causes fluid buildup in the feet, arms , lungs, and other organs, coronary artery disease (common type of heart disease that occurs when the coronary arteries narrow and reduces blood flow to the heart muscle), Hypertension (also known as high blood pressure, is a condition in which the force of blood against the walls of the arteries is consistently too high, Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high. Glucose is our body's main source of energy) and Dementia (a decline in brain function that affects a person's ability to think, remember, and reason). Review of Resident #1's electronic medical record reflected Resident #1 arrived at the facility as a new admit on 01/14/2021 at 5:47 PM and was discharged on [DATE] approximately 8:49 PM. Review of Resident #1's nurses' documentation on 02/21/2025 reflected RN A documented on 01/14/2025 at 5:50 PM, Resident #1 arrived at the building at 5:47 PM. Review of Resident #1's nurses' documentation on 02/21/2025 reflected RN A documented on 01/14/2025 at 7:26 PM MD aware to call in narcotic and aware of Resident #1's arrival. (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

FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676437	If continuation sheet Page 1 of 9
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Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's nurses' documentation on 02/21/2025 reflected (this was the last nurse documentation prior to Resident #1 being discharge) LVN B documented Family unhappy with facility and stated they were going to leave. Obtained vitals before resident departed. VS: BP (blood pressure) 133/78, P (pulse) 72, Temperature 98.1, Respiratory 19, O2 (oxygen) 98 room air, blood sugar 168. Resident #1 departed in wheelchair with family at side. Requested on 02/21/2025 from the Director of Nurses at 8:50 AM the CNA's names and phone numbers scheduled to work on 1/14/2025 and the shift the CNAs worked. Did not receive this information prior to exit. Requested on 02/21/2025 from the Director of Nurses at 9:50 AM all assessments completed on Resident #1 on his admission and discharge date of [DATE]. This was not provided prior to exit. Record review on 02/21/2025 of Resident #1's electronic medical record revealed there were not any assessments completed on Resident #1 on 01/14/2025. Interview on 02/20/2025 at 11:05 AM, the Admission Coordinator stated I completed the paperwork for the facility to give care to Resident #1 prior to him entering the facility on 01/14/2025 approximately 5:45 PM. She stated if she was not in the facility the nurse on duty was expected to greet the resident. Interview on 02/20/2025 at 12:06 PM RN A stated she was working when Resident #1 was admitted to the facility. She stated Resident #1 arrived at the facility approximately 5:47 PM in first part of January. She stated she did not recall the exact date Resident #1 was admitted to the facility. RN A stated the cut off time for the nurse to do admit a resident to the facility was at 5:45 PM. She stated she was not responsible for Resident #1's admission it was the oncoming nurse's responsibility to take over the admission when the nurse arrived at 6:00 PM and after the nurse received report and counted medications. RN A stated she was not certain if anyone met the resident when he arrived by ambulance. She stated she thought a CNA may have spoken to Resident #1 when he entered the facility but she was not certain where the CNA spoke to Resident #1. She stated she did not know if any staff went to Resident #1's room. RN A stated she was not responsible for Resident #1 when he arrived at the facility and she did not notice if anyone went to his room. She stated she did not go to his room and greet him or do any type of assessment on Resident #1 when he entered the facility at 5:47 PM. She stated I have already explained Resident #1 was not my responsibility the cut off time for the nurse on duty to do any type of assessments or give any directions to staff on a new admission was at 5:45 PM. She stated she did write a note after 6:00 PM on Resident #1 and she was still in the facility. She stated she did leave the facility after she documented on Resident #1 about his narcotic medication. She stated she was not aware of when or if the oncoming nurse did an assessment on Resident #1 or when Resident #1's vitals was taken by the nurse. She stated she did not complete any assessments on Resident #1. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/202/2025 at 1:27 PM LVN B stated he worked on the day Resident #1 was admitted to the facility. He stated he arrived at the facility approximately 6 PM and he worked until 6:00 AM the next morning. He stated RN A explained to him any resident arrived at the facility after 5:45 was the oncoming nurse responsibility to do the admission. LVN B stated he believed Resident #1 arrived around 5:47 to the facility. LVN B stated there was no assessments or vitals on Resident #1 when he began duty. He stated he received report from RN A of new admit and this was all the report he received from RN A. He stated he did not go to Resident #1's room until he heard the family was upset. He stated it was approximately 7:40 he went to Resident #1's room and the family was wanting to speak to management. LVN B stated he had not completed any type of assessment or vitals at this time. LVN B stated Resident #1 was upset and had some anxiety when I was speaking with the family. He stated he exited the room and found the Treatment Nurse C and asked her to speak to the family. LVN B stated he did return to the room before Resident #1 was being discharged and obtained his vital signs at that time. He stated from when Resident #1 arrived at the facility around 5:47 PM until approximately 8:49 PM Resident #1 was not assessed by a nurse or vitals was taken by a nurse. LVN B stated he did obtain Resident #1's vitals few minutes before he left the facility. He stated when a resident was admitted to the facility the nurse on duty was to obtain vitals and do a head-to-toe assessment on the resident. He stated he never heard a nurse was not to do anything with a new admit at 5:45 PM. He stated the nurse on duty was to review the EMS packet to ensure it was correct. He stated he did not complete any assessments such as pain or head-to- toe assessments on Resident #1. He stated he only received vital signs when he was being discharged . Interview on 02/21/2025 at 2:00 PM Treatment Nurse C stated she entered Resident #1's room at approximately 7:45 PM after LVN B explained the family was upset and wanted to talk to someone in management. She stated when she entered Resident #1's room the family was very upset over no one had been in his room to check on him and he was soiled. Treatment Nurse C stated she did observe Resident #1 being soiled. She stated I provided care on Resident #1 and changed his soiled clothes. She stated I don't know how long he had been soiled. Treatment Nurse C stated she was not certain if any staff had been in his room. She stated after she cleaned him and changed his clothes the family member of Resident #1 was going to contact another family member to make decision if they should keep him at the facility or discharge him home. She stated when she was giving ADL care to Resident #1 he was upset and anxious he kept saying he was so nervous and upset. Treatment Nurse C stated after a few minutes the family decided to discharge him home. She stated this is when LVN B obtained vital signs. She stated she was not aware of a cut off time when a nurse did not accept a new admission into the facility. Treatment Nurse C stated if she was working and a new resident was admitted to the facility at 5:45 PM and her shift ended at 6:00 PM, she stated I would go to the resident room introduce myself and obtain vital signs and do a head-to-toe assessment. She stated I would give all this information to the oncoming nurse but I would not leave the facility until I felt comfortable that all my documentation on the new admission was completed and gave a full report to the oncoming nurse. Treatment Nurse C stated if the nurse did not go to Resident #1's room when he was admitted and vital signs was not obtained for approximately 2 hours after admission she stated there was a possibility the resident may have high blood pressure, his blood sugar may be elevated, or anything could happen within 2 hours. She stated if the resident was not accustomed in using the call light button he would not know how to use it to get help. The Treatment Nurse C stated she did not complete any assessments on Resident # 1 such as head to toe or pain assessment. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 02/202/2025 at 2:30 PM The Administrator stated her expectation when Resident #1 was admitted to the facility between shift change it was the nurse on duty responsibility to greet Resident #1 and complete a quick head to toe assessment and obtain vital signs. She stated the oncoming nurse was also expected to complete an assessment on Resident #1. The Administrator stated ultimately it was the nurse on duty (RN A) responsibility assess Resident #1 and greeted him. She stated possible negative outcome of Resident #1 not being assessed or vital signs obtained by RN A and LVN B the resident blood sugar may have elevated, possible high blood pressure, pain and not receive any ADL care. The Administrator stated the nurses was neglectful of their duties to provide care to Resident #1. Interview on 02/202/2025 at 4:00 PM the Director of Nurses stated when Resident #1 was admitted to the facility at 5:47 her expectations were the RN A (the nurse on duty when Resident #1 was admitted) to visit Resident #1 in his room and introduce herself and get his vital signs. She stated for the oncoming nurse (LVN B) beginning duty at 6:00 PM, she expected RN A and LVN B to begin their rounds and start with Resident #1. The Director of Nurses stated there was not a cut off time of when an admission was not to be completed. She stated 5:45 PM was not a cut off time for the nurse on duty to not begin the admission process. The Director of Nurses stated this was not the facility protocol. She stated RN A was not expected to complete all assessments but she was expected to begin the admission process and report to LVN B of what she had completed and the results of her findings. She stated there was no an assessment completed on Resident #1 and vital signs was obtained when Resident #1 was discharged from the facility and he had been in the facility approximately over an hour. The Director of Nurses stated there was a possibility Resident #1 may be in distress and if he did not know how to use the call light the nursing staff would not have known it until the family showed up at the facility around 8:00 PM. She stated she was not aware of any assessments completed on Resident #1 except vital signs when he was being discharged . (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/2025 at 2:40 PM with Family Member E via phone stated Family Member F attempted to call Resident #1 and could not get in touch with him. She stated she decided to try and call him and he finally answered his cell phone. Family Member E stated he was upset and it was difficult for him to talk. She stated Resident #1 explained his bed was not locked and he sat on his bed and moved the bed with his good leg and used his cane to guide the bed from one side of the room to another side to get his cell phone. She stated Resident #1 explained it kept ringing and he was afraid something had happened. Family Member E stated Resident #1 explained he needed to go to the bathroom and no one answered the call light and he urinated all over himself, the bed, and the floor. She stated Resident #1 was very upset and did not understand what was going on because he had not seen any staff at the facility. Family Member E stated this had been approximately 45 minutes to one hour since he had been at the facility. She stated she called the facility and did not recall who she spoke to that Resident #1 would be arriving to the facility around 5:30 and he would need assistance and she wanted someone to greet him. She stated she was reassured he would be greeted and someone would assist him to his room and explain the facility to him and give him any care he may need upon arrival to the facility. Family member E stated the reason the family did not go to the facility with him was because the majority of the family had COVID and she had Pneumonia. Family member E stated she told Resident #1 she would be at the facility in a few minutes. She hung up the phone and called Resident #1's and asked her to call him. Family member E stated when she arrived he was half on the bed and part of him was half off the bed. She stated he was soaking wet and there was urine on the bed on Resident #3's pants and his socks was soaked with urine. Family member E stated the bed was not where it was supposed to be due to Resident #1 moved the bed to get his cell phone. She stated the bed was unlocked and she did not know how Resident #3 did not fall. She stated one of his hips is bone rubbing bone and if he falls he may not ever be able to walk again. She stated Resident #1 was so upset and anxious. Family member E stated she had never seen him that upset in her life. She stated she found Treatment Nurse C and she came to the room and when she walked in and saw what was going on with Resident #1, her eyes became wide and she did not say anything. Family member E stated this was after 8:00 PM. She stated when he arrived at the facility around 5:40 until 8:00 PM no one had been in his room and he turned on call light and it was not answered. Family member E stated she was so upset and mad because of the shape Resident #1 was in when she walked in the room. She stated the treatment nurse C did not know he was in the facility and she was the nurse supervisor. She stated she asked the male staff his name and all she could get from him was first name but not his position at the facility. Family member E stated Resident #1 was neglected by the staff working at the facility and she would have never admitted him to this facility if she knew he would not be seen by any staff for an hour or more and he would have to urinate on himself and almost fall due to no one would answer the call light. She stated for a resident to have to move the bed with one leg and a cane to get his cell phone so he could get some help she stated this was unacceptable. Family member E stated Resident #1 vital signs was taken when they decided to leave the facility and take Resident #1 home until they could make a decision about his care. She stated she was shocked in how her father (Resident #1) looked, his emotional state and his physical condition when she entered the room. She stated he was exhausted from moving the bed. Review of the facility's Abuse and Neglect Policy, dated 2009, reflected neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interview and record review, the facility failed to provide sufficient preparation and orientation to resident to ensure safe and orderly transfer or discharge from the facility for one of three (Resident #2) residents reviewed for discharges. The facility failed to provide and document that Resident #2 was given an orientation prior to discharging the resident from the facility and notifying when the resident would be leaving the facility to be transferred to another facility. This failure could place residents at risk of being discharged without a safe and effective transitions of care. Findings included: Review of Resident #3's face sheet, not dated, reflected an [AGE] year-old female who was admitted to the facility on [DATE] . Resident #3 had diagnoses which included Alzheimer's disease (a progressive disorder that gradually destroys memory, thinking skills, and the ability to carry out daily activities), vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance (caused by conditions that reduce or block blood flow to the [NAME] without having any behavior problems), and anxiety (problems with reasoning, planning, judgement, memory and other thought processes without behavior issues), and other abnormalities of gait and mobility (change in a person's walking pattern). Review of Resident #3's Quarterly MDS Assessment, dated 12/19/2025, reflected Resident #3's BIMS score was 99, which indicated Resident #3 was unable to complete the interview. She had poor short- and long-term memory recall. Her decision-making ability was moderately impaired- decisions poor; cues/supervision required. Resident did not have any behavior problems. She had difficulty concentrating. She required substantial/maximal assistance (helper does more than half the effort) with the following: upper and lower dressing, showers, personal hygiene, transfers, bed mobility, and toileting hygiene. Review of Resident #3's Comprehensive Care Plan, with completion date 12/07/2024, reflected Resident #3 had impaired cognitive function/ impaired thought processes related to Alzheimer's. Interventions: Administer medications as needed. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Observe /document/report to Medical Doctor any changes in decision making ability, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. Resident #3 was at risk for falls. Interventions : Anticipate and meet the resident's needs. Ensure that Resident #3 wearing appropriate footwear when ambulating or mobilizing in wheelchair. Resident #3 was an elopement risk/ wanderer. She had a history of attempts to leave the facility unattended, impaired safety awareness, Resident# 3 wanders aimlessly. Interventions: Distract Resident #3 from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book. Requested medical records on 02/21/2025 at 9:13 AM from the Director of Nurses all information related to Resident #3's discharge. (continued on next page)		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 02/21/2025 throughout the day received the following related to Resident #3's discharge: 1. Note from the Administrator related to Resident #3's R/P requesting on 01/14/2025 medical records to be sent to Brenham Nursing and Rehabilitation Center . 2. Nurses note related to Resident #3's discharge date d 01/15/2025 the date of the discharge. 3. Discharge Policy. Record review on 02/21/2025 of Resident #3's discharge nurses note, dated 01/15/2025, reflected Resident #3 discharged to another facility transportation with their staff. Condition stable, able to ambulate to transportation van. Sutures intact to right face, no bleeding/drainage, edema at site. Some redness around right eye No signs/symptoms of pain. Temperature 98, Pulse 63, Blood Pressure 120/78. Signed by LVN D. Interview with Admission Coordinator on 02/21/2025 at 10:15 AM, she stated she had contacted Resident #3's responsible party in few days after Christmas about the possibility of Resident #3 discharging to a secure unit for safety concerns of Resident #3. She stated Resident #3 had been exit seeking. She stated she gave Resident #3's R/P several names of facilities with secure unit. The Admission Coordinator stated Resident #3's R/P called her and was not satisfied with any of the facilities she toured. She stated she had attempted numerous times to call Resident #3's R/P and left messages and she never returned her phone calls. The Admission Coordinator stated the facility did not give the family or resident a 30-day discharge notice. They were concerned with her increase in exit seeking. Interview with the Administrator on 02/21/2025 at 2:30 PM stated Resident #3's R/P contacted her and stated she received a phone call on 01/14/2025 at 9:00 AM giving the facility permission to fax information to another nursing home She stated the medical records were faxed and someone from that facility to came to this facility to assess Resident #3. The Administrator stated she received a phone call from someone at the facility in Brenham and stated they would accept Resident #3. She stated Resident #3 was transferred via facility van on 01/15/2025. She stated she did not have any contact with the family on 01/15/2025. The Administrator stated the only contact she had with Resident #3's R/P during the discharge process was when Resident #3's R/P requested for medical records to be faxed to the other facility. She stated the nurse on duty was expected to call Resident #3's R/P and notify the R/P when Resident #3 left the facility and to explain the discharge to Resident #3. (continued on next page)		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Where the new facility is located. b. How large the facility is, what services it offers, what it looks like, etc. (if known) c. Any information you can about the facility (if you don't know, ask the supervisor about this information.) d. Who will be providing the resident's care (such as nurses, assistants, therapists, etc.) e. That his or her family and visitors will be informed of the discharge and where the resident will be living. f. Why the discharge is necessary (such as closer to home, relatives, etc.) -If the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed and telephone report is called to the receiving facility. -Assess and document resident's condition at discharge, including skin assessment, if medical condition allows. - All ambulatory residents being discharged must be transported to the pick-up area by a wheelchair.		