

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 03/19/2025
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 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview, and record review, the facility failed to ensure parenteral fluid were administered consistent with professional standards of practice in accordance with physician orders, the comprehensive-centered care plan, and the resident's goals and preferences for two (Resident #1 and Resident #2) of two residents reviewed for parenteral fluids. 1. The facility failed to ensure Resident #1's PICC line dressing was changed every 7 days or as needed as Resident #1 went 27 days without a dressing change. Resident #1's dressing was dated 2/20/2025 and was not changed on 02/27/2025, 03/06/2025, and 03/13/2025. 2. The facility failed to ensure Resident #1, and Resident #2 were on enhanced barrier precautions for PICC lines. This failure resulted in the identification of an Immediate Jeopardy (IJ) on 03/18/2025 at 2:25 PM and an IJ template was provided. While the IJ was removed on 03/19/2025 at 6:30 PM, the facility remained out of compliance at no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents with central lines at risk for serious infection, impaired nutrition, and hospitalization . Findings included: Review of Resident #1 face sheet reflected a [AGE] year-old man readmitted on [DATE] with diagnoses of other acute osteomyelitis, left femur, sepsis due to Escherichia coli, type 2 diabetes mellitus, unspecified dementia, malignant neoplasm of prostate, and abscess of bursa. Review of Resident #1 quarterly MDS reflected a BIMS score of 06. Further review reflected Resident #1 had septicemia and received intravenous, antibiotics. Review of Resident #1's physician orders dated 02/20/2025 reflected Resident #1 had a PICC inserted for IV access until 03/19/2025. Review of Resident #1's physician orders dated 02/11/2025 reflected to change IV dressing every seven days and as needed. Resident #1's dressing should have been changed on 02/27/2025, 03/06/2025, and 03/13/2025 and/or as needed. (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 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's physician orders dated 02/11/2025 reflected to administer cefazolin sodium intravenous solution every 8 hours for sepsis until 03/19/2025 through PICC line. Further review reflected orders dated 02/12/2025 to flush IV line before and after administration of IV medication. Observation on 03/18/2025 at 9:53 AM, revealed there were no EBP signage or PPE available for Resident #1. Further observation revealed Resident #1's PICC line dressing was dated 02/20/2025. There was no signs of redness or odor observed at site. During an observation and interview on 03/18/2025 at 11:26 AM, LVN A stated that Resident #1's dressing was dated 02/20/2025. LVN A stated dressings were supposed to be changed at least once a week and if it was not changed the resident could get an infection. LVN A stated she was not sure what residents were supposed to be on EBP. LVN A was observed flushing Resident #1's PICC line with gloves on and no gown. LVN A stated the nurse who was assigned to the resident should change the dressing. LVN A stated she thought she should use a gown and gloves if you were flushing or doing anything with a PICC line. During an observation and interview on 03/18/2025 at 11:43 AM, ADON B stated EBP should have been used on residents who have direct line in or out of the body and any major wound. ADON B stated you should use EBP when you changed dressings or provided personal care. ADON B stated residents who had a PICC line should have been on EBP. ADON B stated he needed to double check whether staff needed to wear a gown to flush the line. ADON B observed Resident #1's dressing and stated, I can tell you right now, that isn't good. ADON B stated that Resident #1's dressing was dated 02/20/2025. During a subsequent interview on 03/18/2025 at 12:23 PM, ADON B stated that he was informed that central supply ran out of dressings two weeks ago and their order was backordered for some time. ADON B stated they should get a new delivery today. ADON B stated he was not aware the facility was out of the dressings. Review of Resident #2's face sheet reflected a [AGE] year-old man admitted on [DATE] with diagnoses of other specified sepsis, infection and inflammatory reaction due to internal right hip prosthesis, abscess of [NAME], staphylococcal arthritis, and hearth failure. Review of Resident #2's physician order dated 03/13/2025 reflected to change foley catheter as needed, and provide catheter care every shift or as needed. Further review reflected to change IV dressing every seven days or as needed. Observation on 03/18/2025 at 10:49 AM, revealed no EBP signage or PPE in or outside of Resident #2's door. Observation on 03/18/2025 at 10:50 AM, revealed facility staff posted EBP sign on Resident #2's door. Observation on 03/18/2025 at 10:55 PM, revealed LVN C flushed Resident #2's line with gloves on and did not have a gown on. (continued on next page)		

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/18/2025 at 11:26 AM, LVN C stated that dressings were supposed to be changed every 7days and if there were not an infection could occur. LVN C stated residents who had a PICC line were usually on EBP. LVN C stated EBP was used to provide personal care such as showers. LVN C stated that only gloves could be used for flushing, and it was not considered personal care. During an interview on 03/18/2025 at 1:38 PM, DON stated that EBP should have been used on residents with a foley, PICC, IVs and wounds. She stated that this included using gloves, gown and mask when care was provided. DON stated resident with PICC lines should be on EBP. She stated PPE should have been just inside or just outside of the resident's room. She stated that when staff handled the PICC lines they should have implemented EBP. DON stated the purpose of EBP was to possibly prevent infection. DON stated she was not aware that Resident #1's dressing had not been changed since 02/20/2025. DON stated the nurse was responsible for putting in the orders and changing the dressing when it was needed. DON stated ADONs should have monitored that orders were initiated and PICC dressings were changed. DON stated dressings should be changed every seven days. She stated the potential outcome of not changing the dressing or using EBP was possible introducing an infection. DON stated central supply was responsible for ordering supplies and that PICC line dressings were on back order. DON stated they had one dressing in the facility today and she just learned that there was a PICC dressing shortage. During an interview on 03/18/2025 at 1:18 PM, MD stated that dressing was supposed to be every seven days and as needed. MD stated there was a risk for infection if the dressing was not changed but it was not anything outrageous and stated Resident #1's dressing should have been changed. MD stated there are no standing orders for EBP, but she would expect the staff to have EBP PPE on such as gown and gloves. Review of facility policy titled Central Venous Catheter Dressing Changes with revision date of April 2016 reflected the purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. Further reviewed reflected general guidelines included to change dressings at least every 5-7 days and PRN. Review of facility policy titled Enhanced Barrier Precautions - Policy dated 04/01/2024 reflected the use of gown and gloves during high-contact resident care activities were required. High-contact resident care activities included device care or use such as central line or urinary catheter. Further review reflected indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. The ADM and DON were notified on 03/18/2025 at 2:25 PM, that an IJ had been identified. An IJ template was provided, and a POR was requested. The following POR was approved on 03/19/2025 at 12:19 PM and indicated: Plan of Removal (continued on next page)		

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A. On 3/18/25, an abbreviated survey was initiated at the facility. The surveyor provided an Immediate Jeopardy Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy stating the facility failed to ensure resident #1's PICC line dressing was changed every 7 days. The facility failed to ensure resident #1 and resident#2 were on enhanced barrier precautions for PICC line. What corrective actions have been implemented for the identified residents? B. On 3/18/2025 at 2:25pm, resident #1's PICC line dressing change was done by Nurse Manager A. C. On 3/18/2025 at 2:25pm, resident #1 was placed on enhanced barrier precautions and signage posted on resident #1's door by Nurse Manager A. D. On 3/18/25 at 2:30pm, resident #2 was placed on enhanced barrier precautions and signage posted on resident #2's door by Nurse Manager A. E. On 03/18/2025 at 2:40pm the Administrator notified the Medical Director of the alleged deficient practice. F. The Corporate Clinical Service Director in-serviced the Nurse Managers on 3/18/25 at 3:30pm on ensuring PICC line dressing change is done every 7 days. G. On 3/18/25 at 4pm Nurse Manager A and B completed an assessment of 2 residents with PICC line to ensure the dressing change date is less than 7 days, and no concerns were identified. H. Nurse Managers completed a 100% audit of residents residing in the facility to assess the need for barrier precautions, no concerns were identified. I. On 3/18/2025 licensed nurses were in-serviced on ensuring PICC line dressing change is done every 7 days by Nurse Manager A and B. The facility audited all residents with PICC line for dressing change dates less than 7 days old, no concerns were identified by Nurse Manager A and B. J. The Corporate Clinical Service Director reviewed facility policy on 3/18/2025 regarding PICC line dressing change and no revisions were deemed necessary. K. The Corporate Clinical Service Director reviewed facility policy on 3/18/2025 regarding enhanced barrier precautions and no revisions were deemed necessary. How were other residents at risk to be affected by this deficient practice identified? A. All residents have the potential to be affected by the alleged deficient practice. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? A. An in-service was completed on 3/18/2025 by the Corporate Clinical Service Director with the Director of Nursing on ensuring residents PICC line dressing change is done every 7 days. (continued on next page)		

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	B. An in-service was completed on 3/18/25 by the Corporate Clinical Service Director with the Director of Nursing on ensuring residents requiring enhanced barrier precautions have signage posted on the door. C. The Director of Nursing completed an in-service on 3/18/2025 with the licensed nursing staff on ensuring PICC line dressing change is done every 7 days. D. The Director of Nursing completed an in-service on 3/18/2025 with the licensed nursing staff on ensuring residents requiring enhanced barrier precautions have signage posted on the door. E. Nurses will not be allowed to return to work until they receive this in-service. Nursing staff who are unable to physically attend the in-service training in person will be in-serviced via phone by Nurse Manager A. The completion date is 3/19/2025. F. Newly hired nurses will be in-serviced by the Director of Nursing or designee to ensure PICC line dressing change is done every 7 days during facility orientation upon hire. G. Newly hired nurses will be in-serviced by the Director of Nursing or designee to ensure residents requiring enhanced barrier precautions have signage placed on the door during facility orientation upon hire. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the removal was completed on 3/18/2025 with the Medical Director. The Medical Director has reviewed and agrees with this plan. Surveyor monitored the POR on 03/19/2025 as followed: Observation on 03/19/2025 at 11:32 AM revealed Resident #1's dressing was changed and dated for 03/18/2025. No odor or redness was observed. Observation revealed EBP signage on door and PPE such as gown and gloves in bind inside of Resident #1's room. Observation on 03/19/2025 at 11:39 AM, revealed EBP signage posted on Resident #2's door and bin of PPE such as gown and gloves outside of Resident #2's door. Review of facility in-service dated 03/18/2025 completed by corporate nurse reflected EBP signage must be posted on door and PICC line dressing change was done every 7 days was completed with DON, ADON B and ADON D. Review of in-services dated 03/18/2025 and 03/19/2025 by ADON D reflected 56 staff were educated on EBP. Review of in-services dated 03/18/2025 and 03/19/2025 by ADON D reflected 8 nurses were in-serviced on PICC line dressing changes. Review QAPI sign-in sheet undated reflected medical director, ADM, DON and ADONs attended. (continued on next page)		

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/19/2025 at 4:47 PM, ADON B stated that facility nursing staff (CNAs and nurses) work 12-hour shifts. ADON B stated that all nursing staff was called yesterday and if they answered they were in-serviced via telephone or left a voicemail requesting a return phone call. ADON B stated that staff would be in-serviced prior starting their shift if they had not already been in-serviced. During interviews conducted on 03/19/2025 between 3:45 PM and 6:12 PM, 2 RNs, 2 ADONS, DON, 3 LVNs and 6 CNAs it was revealed that staff received an in-service either on 03/18/2025 or 03/19/2025 or prior to their shift by ADON D or ADON B. Staff stated that in-service included that EBP were to be used with residents who have an open wound, catheter, PICC line, or feeding tube to prevent infection from staff to the resident. Staff stated that EBP included to use PPE such as gown and gloves when they provided direct care such as flushing the line, changing the dressing, peri care and/or showers. Staff stated they can tell to use EBP with a resident on signage that was posted and PPE bin in or outside the resident's room. Licensed nurses stated that PICC line dressings were to be changed every 7 days or as needed to prevent infection to the resident. Licensed nurses stated that they should wear a gown and gloves when changing the dressings or flushing the line for residents with PICC lines. Licensed nurses stated that upon admission they can post EBP signage and get PPE needed or if they notice a resident was supposed to be on EBP. The ADM and DON were notified on 03/19/2025 at 6:30 PM that the IJ had be lowered. While the IJ was lowered, the facility remained out of compliance at a level of no actual harm that was not immediate jeopardy at a score of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.		