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	12/14/2025

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 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. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs) received necessary services to maintain personal hygiene for one (Resident #1) of seven residents reviewed for ADLs, in that: The facility failed to provide showers to Resident #1 in compliance with her shower schedule. This deficient practice could place residents at risk of a decline in hygiene, at risk of skin breakdown, level of satisfaction with life, and feelings of self-worth. Findings included:Review of Resident #1's face sheet dated 12/10/2025 revealed she was a [AGE] year-old female admitted on [DATE] with diagnosis that included: fracture of the right lower leg, asthma (breathing disorder), type 2 diabetes (blood sugar regulation disorder) and history of falling. Face sheet reflected Resident #1 was her own responsible party. Review of Resident #1's admission MDS dated [DATE] reflected a BIMS of 15, suggesting she was cognitively intact. Review of the functional abilities section reflected resident was coded as a 2 substantial/maximal assistance' for the activity of shower/bath self. Resident was coded as a 1 dependent - helper does ALL the effort for the activity tub/shower transfer. Review of Resident #1's care plan dated 11/3/2025 reflected the following focus areas: [Resident #1] has potential/actual impairment to skin integrity r/t surgical wound medial ankle with intervention keep skin clean and dry. [Resident #1] has potential/actual impairment to skin integrity r/t surgical wound right lateral ankle with intervention keep skin clean and dry. Further review of care plan indicated no entries for bathing or hygiene. Review of Resident's ADL bathing task records in the EMR reflected Resident #1 did not get a shower on 11/17/2025, 11/19/2025 and 12/52025, her scheduled shower days. Review of Resident #1's progress notes from 11/10/2025 to 12/10/2025 reflected no progress notes regarding why showers were not completed on 11/17/2025, 11/19/2025 and 12/5/2025. During an interview 12/10/2025 at 12:37 pm, FM #1 stated Resident #1 was admitted to the facility post ankle surgery and was not allowed to bear weight on the injured foot. They stated she relied heavily on staff to help her bathe and use the restroom. They stated Resident #1 ended up with a wound infection and they believe it was because the facility did not bathe her like they were supposed to. They stated they were aware of one time when resident refused a bath but were not aware of any other refusals by Resident #1. During an interview on 12/10/2025 at 4:50 pm, the DON stated she was not aware of any shower issues with Resident #1. She stated staff chart in the EMR under tasks whether a resident gets a bath or not and any refusals. She stated if a resident refuses, the aid was supposed to let the nurse know so they can follow up. If a resident still refuses, the nurse should put in a progress note. During an interview on 12/11/2025 at 12:10 pm, FM #2 stated they visited Resident #1 frequently and never saw her being bathed. They stated one visit - they could not remember the date - Resident #1 stated she hadn't had a bath in a week and a half. FM #2 stated they said something to one of the staff and Resident #1 got a bath the next day. During an interview on 12/11/2025 at 12:53 pm, Resident #1 stated she did not get baths the way she was supposed to. She stated, the only time I can remember refusing was when I was watching the Aggie game and it was the Friday after Thanksgiving. She stated they would take her to the shower room and give her a shower while she sat on bench. She said her shower schedule was Monday, Wednesday, Friday, but staff often gave her a bath off schedule. Resident #1 stated many times the staff would not even ask her if she wanted a bath and a family member would have to go get them to get it done. During an interview on 12/12/2025 at 10:45 am, the DON stated that Resident #1 refused a shower on 12/05/25. DON stated there was a late entry regarding the resident's refusal put in by the nurse on 12/11/2025. During an interview on 12/14/2025 at 6:32 pm, the ADM stated it was her expectation that showers be given per the shower schedule. She stated it is the responsibility of the charge nurses to make sure they are done, the aides need to let the nurses know if there are any refusals, so they can put in a progress note. She stated a possible negative effect of residents not getting showers will have a body odor and she wants her residents clean. During an interview on 12/14/2025 at 6:45 pm, the DON stated it was the responsibility of the nurse on the unit to make sure residents are getting showers and her expectation was that the CNA would give the shower, and the resident gets the shower and they have a shower schedule. She stated a possible negative. effect of someone not getting a shower is that the resident is not clean, but the resident has a right to refuse a shower, and the nurse needs to document when this happens. Review of facility policy Shower/Tub Bath dated revision October 2011 reflected: PurposeThe 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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were free from unnecessary drugs for one resident (Resident #1) of seven reviewed in that: The facility failed to follow Resident #1's Nephrologist's orders on 11/13/2025 to discontinue medications metformin, potassium citrate, prenatal vitamin, valsartan-hydrochlorothiazide. This failure affected Resident #1 and could have affected all residents receiving medication by placing them at risk of illness, toxicity, or other adverse reactions. Findings included: Review of Resident #1's face sheet dated 12/10/2025 revealed she was a [AGE] year-old female admitted on [DATE] with diagnosis that included: fracture of the right lower leg, asthma (breathing disorder), type 2 diabetes (blood sugar regulation disorder) and history of falling. Face sheet reflected Resident #1 was her own responsible party. Review of Resident #1's admission MDS dated [DATE] reflected a BIMS of 15, suggesting she was cognitively intact. Review of Resident #1's After Visit Summary from the Nephrologist office dated 11/13/2025, reflected: STOP taking these medications:Metformin 500 MG [blood sugar regulation medication]potassium citrate 1 meq [potassium supplement]prenatal vitamin 28 mg/800mcg valsartan-hydrochlorothiazide 320-12.5mg [blood pressure medication] Review of Resident #1's November 2025 MAR reflected she received the medications Metformin, potassium citrate, and valsartan-hydrochlorothiazide from 11/13 - 11/30. Review of Resident #1's December 2025 MAR reflected she received the medications Metformin, potassium citrate, and valsartan-hydrochlorothiazide on 12/1/2025 and 12/2/2025 until they were discontinued on 12/2/2025. Review of Resident #1's progress notes from 11/13/2025 to 11/26/2025 reflect no entries regarding the discontinuation of medications as ordered by Resident #1's Nephrologist. Review of Resident #1's progress notes dated 11/27/2025 reflected: Pt [FM2] stated pt had went to a Nephology visit on the 13th and the Nephrologist of the patient made orders to stop completely taking Metformin, [Potassium] Citrate, Prenatal Vitamins, and Valsartan-hydrochlorothiazide, and Neurontin, and Meloxiam and to gradually stop taking Protonix r/t Kidney function. MD Notified of [FM2] concerns orders pending. Review of Resident #1's progress notes dated 12/2/2025 reflected: Nephrology office did not call back. [FM2] stated she would email the orders indicating which meds the MD wanted DC'd. I discussed with [MD]. She gave orders to DC the Mobic, Gabapentin, Protonix and started Pepcid 20 mg daily. Orders updated.11/13/25 Office visit from Nephrologist indicated to DC the following meds: Prenatal vitamin Valsartan- HCTZ, Metformin, Potassium Citrate. Orders updated. During an interview on 12/11/2025 at 12:53 pm, Resident #1 stated a facility staff took her to her Nephrologist appointment 11/13/2025 and afterwards she handed the paperwork to the staff. She stated she thought she was going to give it to the nurse, but she didn't watch to see if she did this. During an interview on 12/11/2025 at 1:53 pm, FM #3 stated Resident #1 had a visit with the Nephrologist on 11/13/2025 and was transported by the facility to the appointment. FM #3 stated they were on the phone with Resident #1 while at the appointment with the Nephrologist and heard him say he wanted medications discontinued to protect her kidneys. The stated Resident #1 told her she handed the after-visit summary paperwork to the facility staff on 11/13/2025 after the appointment and they were supposed to give it to the nurse. They started on 11/27/2025, when Resident #1 was brought back after Thanksgiving, they asked the nurse about why the resident was still taking the medications and why they were not discontinued back on 11/13/2025 and the nurse stated she would call the doctor. They stated they were very upset that the specialist had discontinued the medications two weeks prior and the facility was still giving them to the Resident #1. During an interview on 12/11/2025 at 4:25 pm, MD stated she did not remember staff calling her about discontinuing medications for Resident #1. She stated just because she cannot remember someone not calling - doesn't mean they did not. She stated she does know if they had called her about discontinuing the meds from the nephrologist -her answer would be to discontinue the medications and follow orders of the specialist - she stated, I don't argue with a nephrologist. She wouldn't argue with a doctor that has been treating a patient long term. During an interview on 12/12/2025 at 12:30 pm, the DON stated Resident #1 was taken to the nephrologist by a family member. DON stated that when the resident returned to the facility there was no paperwork. DON stated there was a nursing progress note on 11/13/25 regarding the issues. DON stated when the facility transports a resident to an appointment the transportation staff gets all paperwork and returns it to the facility. The nurse on the unit is responsible for completing follow up. The expectation is for the nurse to follow up with the clinic regarding visits and continue to follow up until the visit information is obtained. If a family takes a resident to an