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 01/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for 1 of 5 residents (Resident #1 observed for resident rights. The facility failed to ensure Resident #1 was treated with respect when Resident #1's personal cell phone was placed on the bedside rolling table, where she could not reach it, by ADON A when she was talking to her son while she was in respiratory distress. This failure could place residents at risk lack of advocacy and frustration. Findings included: Review of Resident #1's face sheet, dated 01/14/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses unspecified diastolic congestive heart failure (heart's main pumping changer is stiff and cannot relax or fill properly with blood between beats, causing fluid backup (congestion), essential hypertension (high blood pressure with no single identifiable cause), paroxysmal atrial fibrillation (a type of irregular heartbeat where episodes start and stop suddenly, usually resolving on their own or with treatment withing seven days, often ending within minutes to hours), generalized anxiety disorder (a mental health disorder that produces fear, worry and a constant feeling of being overwhelmed), recurrent depressive disorder (caused by traumatic or stressful life events), nonrheumatic aortic valve stenosis (the hearts aortic valve narrows, most commonly age-related or a congenital defect, restricting blood flow from the heart to the body and forcing the heart to work harder, potentially leading to heart failure), Review of Resident #1's Medicare MDS Assessment, dated 11/18/2025, reflected Resident #1 had a BIMS score of 15 indicated her cognition was intact. Resident #1 had diagnosis of anxiety and depression. Review of Resident #1's Comprehensive Care Plan, dated 01/08/2026 reflected Resident #1 was taking anti-depressant medication. Intervention: Psych services as indicated. Social Services to evaluate and provide emotional support as needed. Observation of Resident #1's video from her room dated 01/13/2026 at 7:51 am, revealed ADON A stated I am going to remove your phone from your chest and Resident #1 nodded her head no and held up her left hand. She became more frustrated and ADON A left the room when she removed the phone from Resident #1. Resident #1's family member was on the phone, and Resident #1 attempted to reach the phone. The phone was placed on rolling bedside table where Resident #1 was unable to reach it. The bedside rolling table was not beside Resident #1. The bedside rolling table was to the right side of the bed, approximately 10 feet from Resident #1, towards the middle of the right side of the bed. Approximately 8 minutes later, EMS walked into the room and picked up the cell phone and began talking to Resident #1 son. During the time the cell phone was removed from Resident #1's chest, Resident #1's hands were not shaking. Resident #1 was holding the cell phone in her left hand prior to laying it on her chest. In an interview on 01/14/2026 at 12:01 p.m., ADON A stated Resident #1 was having difficulty with breathing, and her phone was near her chest. She stated the phone had an effect on Resident #1's breathing. ADON A stated the phone lying on Resident #1 chest was not good for (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breathing. She stated Resident #1's son was on the phone talking to Resident #1 when she removed the phone from Resident #1 chest and placed it on the bedside table, within reach of Resident #1. She stated Resident #1 was able to reach the cell phone from where she was lying in bed. ADON A stated the bedside rolling table was not located on the right side of the bed and was not toward the middle of the bed, instead it was directly beside Resident #1, at the head of the bed. ADON A stated it was Resident #1's right to have her cell phone when her son was on the phone speaking to Resident #1. She stated Resident #1 was not able to hold the cell phone with her hand. ADON A stated Resident #1's hands were shaking, and she was not capable of holding a cell phone. ADON A stated she was expected to follow resident rights and had been in-service on resident rights. She stated she did not recall the time or date of the in-service. ADON A stated she did not have anything else to say about the cell phone, that was all she knew to report about the situation of the phone. In an interview on 01/16/2026 at 4:00 pm, the Director of Nurses stated anytime a Resident was on their personal cell phone with a family member, and they find comfort having their family member on the cell phone when they are in distress or not in distress it was against resident rights for a staff to remove the cell phone from the resident. She stated ADON A was not to remove the cell phone from Resident #1 and place it where Resident #1 could not reach it. The Director of Nurses stated a resident had a right to speak to their family anytime they choose, and to have their cell phone within reach. She stated all staff had been in-service on resident rights. She stated she had not interviewed ADON A about the incident with Resident #1, and the facility was going to conduct a full investigation of what occurred with Resident #1 on 01/13/2026. In an interview on 01/16/2026 at 4:35 pm, the Administrator stated all residents had a right to have access to using phone to contact family. She stated if a resident had a personal cell phone and a family member was on the phone with the resident, it did not matter what the situation was, the staff was not to take the cell phone away from a resident while family was on the phone. The Administrator stated if a resident had a cell phone, and not using it, the staff was not to place a resident's cell phone outside of the reach of the resident. She stated a resident's personal cell phone was expected to be within reach of the resident at all times, especially when the resident's family was talking to the resident on the phone. She stated that was against the resident's rights. The Administrator stated all staff had been in-serviced on resident rights, and she did not recall the date or time of the in-service. She stated the facility was completing an investigation of what occurred with Resident #1 on 01/13/2026. The Administrator stated she would be conducting further investigation about the situation with the cell phone incident that occurred on 01/13/2026. Record review of the facility's policy on Resident Rights, dated 2009, reflected Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident to use a telephone in privacy. Residents are entitled to exercise their rights and privileges to the fullest extent possible. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a comprehensive care plan was reviewed and revised by theinterdisciplinary team after each assessment for 1 of 5 (Resident #2) reviewed for care plans. The facility failed to ensure Resident #2's care plan was revised to reflect Resident #2 was on Enhanced Barrier Precautions . This failure could place residents at risk of not receiving appropriate care to meet their needs. Findings included: Review of Resident #2's Face sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of sepsis, unspecified organism (a serious medical conditions characterized by the body's extreme response to an infection, where the specific organism causing the infection is not identified. It can lead to organ failure), perforation of intestine (a hole or tear in the intestinal wall, allowing digestive contents like food, bacteria, bile, and acid to leak into the abdominal cavity, causing severe infection and potentially life-threatening sepsis), colostomy status (a surgically created opening in the abdominal wall that connects the colon to the outside of the body, allowing waste to bypass a damaged or diseased part of the lower bowel), and malignant neoplasm of rectum (cancer forming in the tissues of the rectum). Review of Resident #2's MDS Assessment, dated 01/01/2026, reflected Resident #2 had a BIMS score of 13 indicated his cognition was intact. Resident #2 had a colostomy. He had diagnosis of septicemia (body's extreme response to an infection that enters the bloodstream) and sepsis. Review of Resident #2's Comprehensive Care Plan, revised on 01/07/2026, reflected Resident #2 had an ostomy secondary to bowel perforation. He was at risk for complications including but not limited to stoma, irritation and bleeding. Interventions: Colostomy care every shift as needed. Monitor for signs of infections such as edema, redness, increased pain around the stoma area. There was not a care plan for Resident #2 to be on enhance barrier precautions. Interview on 01/16/2026 at 4:00 pm, the Director of Nurses stated Resident #2's care plan should have been revised on 01/07/2026. She stated either the ADON or DON was responsible for updating care plans. The Director of Nurses stated they hired an MDS nurse, however, she would begin working next week. She stated if a Resident had an order for enhanced barrier precautions, the nurse reviewing the physician order could have added it to the care plan. The Director of Nurses stated all information about a resident was to be care planned, including enhanced barrier precautions. She stated the interdisciplinary team, and all staff was to follow what was documented on the plan of care for each resident, and if enhanced barrier precautions was not on the care plan, there was a possibility if a nurse reviewed the care plan, the nurse may not know how to use PPE prior to entering the resident's room, if the enhanced barrier precaution sign fell off the door of the resident's room. Interview on 01/16/2026 at 4:35 pm, the Administrator stated she expected any time there was a change of condition or change of treatment, it was to be immediately added to the resident's care plan. She stated if a resident had a new order for enhanced barrier precautions, she expected the nurse, DON, or the Interim nurse completing care plans, to implement this on the resident's care plan. She stated if enhanced barrier precautions were not on a resident's care plan, there was the potential for a nurse, or any staff who may review the care plan, not realize to follow the facility's enhanced barrier precautions protocols. She stated if a staff did not follow enhance barrier precautions, there was a possibility bacteria could be spread to another resident. She stated ultimately, the Director of Nurses was responsible for ensuring the care plans were completed and revised until the new MDS nurse began working next week. She did not recall the exact hire date for the new MDS nurse. Record review of the facility's policy on Comprehensive Care plan, dated December 2015, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.The Interdisciplinary Team must review and update the care plan:1. When there has been a significant change in the resident's condition.2. When the desired outcome is not met;3. When the resident has been readmitted to the facility from a hospital stay; and4. At least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person -centered care plan, and the residents' choice for one (Resident #1) of 5 residents reviewed for quality of care.The facility failed to promptly identify and intervene for an acute change in Resident #1's condition related to congestive heart failure (CHF), resulting in the family calling 911 to transport the resident to the hospital. The resident was admitted to the hospital with respiratory distress and pulmonary edema.An Immediate Jeopardy (IJ) was identified on 01/28/2026. The IJ template was provided to the facility on [DATE] at 12:16 PM. While the IJ was removed on 01/29/2026, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm due to staff needing more time to monitor the plan of removal for effectiveness.This failure placed residents at risk for not being provided the care and treatment required to meet their needs.Findings included: Review of Resident #1's face sheet, dated 01/14/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: generalized anxiety disorder (a chronic mental health condition marked by excessive, persistent, and uncomfortable worry about everyday things like health, work, and family that's hard to control and interfere with daily life), unspecified diastolic congestive heart failure (heart's main pumping chamber is stiff and cannot relax or fill properly with blood between beats, causing fluid backup (congestion), essential hypertension (high blood pressure with no single identifiable cause), paroxysmal atrial fibrillation (a type of irregular heartbeat where episodes start and stop suddenly, usually resolving on their own or with treatment within seven days, often ending within minutes to hours), nonrheumatic aortic valve stenosis (the heart's aortic valve narrows, most commonly age-related or a congenital defect, restricting blood flow from the heart to the body and forcing the heart to work harder, potentially leading to heart failure), end stage of renal disease (your kidneys have failed and can no longer effectively filter waste from your blood, requiring dialysis or a kidney transplant for survival, as kidneys lose their ability to function, leading to waste buildup and serious body-wide problems). Review of Resident #1's Medicare MDS Assessment, dated 11/18/2025, reflected Resident #1 had a BIMS score of 15 which indicated her cognition was intact. She required assistance with dressing, personal hygiene, bed mobility, transfers, and bathing. She did not have any shortness of breath or difficulty with breathing . Review of Resident #1's Comprehensive Care Plan, dated 01/08/2026 reflected: Resident #1 had altered cardiovascular status related to congestive heart failure . Interventions: Give oxygen as ordered by the physician. Assess fingers and toes for warmth and color. Resident #1 had the potential for signs and symptoms and complication related to hypertension. Intervention: Avoid taking blood pressure reading after physical or emotional distress. Document and report to the MD as needed any signs or symptoms of malignant hypertension: headache, difficulty breathing, seizure activity, irritability, lethargic, confusion and/or visual problems. Give medications as ordered. Resident #1 needed hemodialysis (a life-sustaining medical treatment for kidney failure that uses a machine with an artificial kidney to filter waste products, excess fluids, and toxins from the blood, mimicking healthy kidney function) related to renal failure. Interventions: Report significant changes in pulse, respirations and blood pressure immediately. Resident #1 was on diuretic therapy. Interventions: Administer medications as ordered. Resident #1 had CHF (congestive heart failure- (a long-term condition where the heart muscle weakens and cannot pump enough blood to meet the body's needs.) and is on dialysis. Resident #1 uses anti-depressant medication. Interventions: Monitor for side effects such (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	as agitation, emotional blunting (a mental state characterized by a significant reduction in the intensity of emotions, leading to feelings of numbness, detachment, or indifference to both positive and negative events), dry mouth , and restlessness. Review of Resident #1's Late Entry Nurses Notes, dated 01/13/2026 at 7:30 AM reflected new order for Oxygen. Primary Care Provider feedback responded family called 911. Primary Care Physician approved for transferring resident to emergency room. Review of Resident #1's Nurses Notes, dated 01/13/2026 at 8:16 a.m. reflected ADON A entered Resident #1's room approximately at 7:45 a.m. Resident #1 was sitting upright in bed on 2 L/min oxygen via nasal cannula. SpO2 94%, Respirations 20. Room Temperature was 74 degrees Fahrenheit. Resident #1's family member was on phone and repeatedly instructed staff to call 911. Attempted to reposition Resident #1; Resident #1 refused. Breathing treatment was offered and declined. When asked what exacerbated or relieved symptoms, Resident #1 declined to answer and did not engage with staff (ADON A) Resident #1 closed eyes and vocalized softly. When family member asked if Resident #1 was okay, Resident #1 responded clearly and without difficulty stating No, I just need you to do something or come here to help. Resident #1 looked at this nurse (ADON A) and stated 911. Resident #1 remained upright in bed. Resident #1 was offered breathing treatment and refused. Resident #1 was restless. Signed by ADON A. Review of Resident #1's Physician Orders, dated12/01/2025, reflected Resident #1 was on medication for depression. O2 at 2L/minute via PRN as needed for shortness of breath. Review of O2 Sats Summary dated 01/13/2026 at 7:35 am reflected Resident O2 SATS was 92 percent at room air. Resident #1's O2 Sats from 10/16/2025 to 01/13/2026 averaged between 91 percent to 98 percent at room air. Observation of video in Resident #1's room revealed on 01/13/2026 at 7:26 AM Resident #1 asked LVN B for oxygen. LVN B stated, You are right. You may need oxygen. Your face looks flushed . LVN B obtained vital signs, blood pressure and O2 saturation, and stated her O2 Sat was 92 percent. Resident #1 continued to ask for oxygen. The television was on in the room, and there were times when the television was loud, and it was difficult to hear all the conversation. Resident #1 began to become very anxious. She had grimacing facial expression and began to breathe heavier (her chest was moving faster). Resident #1 continued to ask for oxygen. LVN B stated to Resident #1, do you want another nurse to take care of you. Resident #1's tone of voice changed to a crying sound, and she was having difficulty with talking and held her chest. She kept repeating I need oxygen. LVN B collected her medical devices, and exited the room at 7:31 a.m. Observation of video of Resident #1 in her room on 1/13/2026 at 7:33 a.m. revealed Resident #1 was talking on her phone, and it was difficult to understand what she was saying due to the television being loud and she having difficulty talking. Resident #1 continued to breathe heavier, and her chest was moving faster when she would speak. Observation of video of Resident #1 in her room on 01/13/2026 at 7:37 a.m. revealed LVN B returned to the room with oxygen and stated your O2 Sat is 97 percent. LVN B placed oxygen on Resident #1 at 7:39 a.m. and exited the room at 7:40 a.m. Observation of video of Resident #1 in her room on 01/13/2026 at 7:40 a.m. revealed Resident #1 was moaning and making crying sounds. She had her personal phone on her chest. ADON A entered Resident #1's room at 7:41 a.m. Resident #1 was crying and stated she could not breathe. ADON stated, You can't breathe? You are on oxygen Is the O2 not helping you ? Resident stated, call 911. ADON stated you want to call 911. Resident #1 stated she couldn't breathe. ADON A stated she needed to assess her. ADON A did not assess Resident #1, and asked Resident #1 why are you not talking to me? You are talking to your family member. Resident #1 became more frustrated and anxious. Her chest was moving faster and she could barely speak. ADON A asked, what can we do to help you right now. Resident #1 did not respond to the question. ADON A stated, you are talking to your [family member] and won't talk to me. Resident #1 stated I can't breathe. ADON A asked Resident #1 if she (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wanted a breathing treatment. Resident #1 did not respond. ADON did not check her O2 sats, blood pressure, oxygen tank, or tubing. She exited the room at 7:44 a.m. ADON A re-entered Resident #1's room at 7:51 a.m. and she checked the temperature of the room. ADON A stated you need to speak to me. you are talking to your [family member] on the phone but won't speak to me. Resident #1 stated call 911 I can't breathe. ADON A removed Resident #1's phone from her chest and placed it on the rolling table, where Resident #1 was unable to reach the phone. ADON A stated your O2 Sats is 94. ADON A did not check her O2 Sats. EMS entered Resident #1's room at 7:52 a.m. Resident #1 was attempting to reach her cell phone and was stating to the EMS her [family member] was on the phone. She was unable to reach her cell phone to give it to the EMS. EMS picked up the phone and asked if Resident #1 was complaining of shortness of breath. EMS stated to family member via cell phone, we are checking her on our monitor. Does she have any other issues other than Congestive Heart Failure? . EMS stated Her O2 Sat is 79 %. I can understand why she was having shortness of breath. EMS explained to the family member on the phone and to Resident #1 they would be transferring her to the hospital and asked their hospital preference. Observation and interview on 01/14/2026 at 5:40 PM of five residents' (Resident # 3, Resident #4, Resident #5, Resident #6 and Resident #7) oxygen tanks in their rooms revealed there were no concerns with oxygen tanks. Residents did not have any concerns of receiving oxygen or having issues with their oxygen tanks. Record review of Resident #1's hospital records reflected Resident #1 arrived at the ER on [DATE] at 8:15 a.m. [Resident #1] had history of CKD, CAD, presents the emergency department with respiratory distress, [Resident #1] gets hemodialysis Tuesday, Thursday and Saturday. She woke up this morning having respiratory distress she tried to have the nursing facility call EMS to bring her to the hospital and the facility declined. Resident #1 called her [family member] and he called EMS to bring [Resident #1] to the emergency department at that point EMS reports that she was on 2 L nasal cannula and oxygen saturations were in the 70's. [Resident #1] placed on CPAP with improvement. [Resident #1] did not have any other complaints at this time. Resident #1 was admitted to the hospital for respiratory distress in setting of volume overload. Resident #1's chest radiographs revealed findings consistent with volume overload with trace right pleural effusion (an early or mild buildup of excess fluid throughout the body that has resulted in a tiny, minimal amount of fluid collecting in the membrane space surrounding the right lung). Resident #1 was admitted to the hospital. In an attempted interview on 1/14/2026 at 11:05 AM attempted to contact Resident #1 via phone but was unable to leave a message. Resident #1 was in the hospital. In an interview on 01/14/2026 at 12:01 p.m., ADON A stated she entered Resident #1's room approximately 7:45 a.m. on 01/13/ 2026, upon request of LVN B. She stated Resident #1 was sitting upright in the bed and she was on 2 liter(s per minute) of oxygen. She stated Resident #1 was upset and she could not understand what Resident #1 was saying to her. ADON A stated Resident #1 did state she was having shortness of breath. ADON A stated she complained about that a lot. She stated she began to assess her. ADON A stated she checked her O2 sats, blood pressure, oxygen tank, and the room temperature. ADON A stated she was only in Resident #1's room one time. She stated Resident #1 would say she was having difficulty with breathing, and her family member was on Resident #1's cell phone. She stated her oxygen saturation was 94 percent . She stated she used the pulse oximeter three times when she checked Resident #1's O2 sats and it was 94 percent each time. ADON A stated she checked the oxygen tubing in Resident #1's nose to ensure it was secure. ADON A stated Resident #1 became more frustrated and anxious with the questions she was asking about what she could do to help her. ADON A stated Resident #1 stated 911. ADON A stated she removed the cell phone from Resident #1's chest and placed it on the bedside table right beside her bed where she could reach it. ADON A stated Resident #1's family (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	member was on the phone when she removed it from Resident #1's chest. She stated she did not speak to the family member. ADON A stated EMS entered the room and took over with assessing Resident #1. ADON A stated if a Resident asked for 911 to be called, the facility staff was expected to call 911. She stated she did not call 911 or anyone about Resident #1's complaints of having shortness of breath.ADON A did not respond why she did not call 911. ADON A did not reply why she did not call 911. She stated she did not call the physician or report the resident's complaint of having difficulty with breathing and wanting to go to hospital to anyone. ADON A stated she had been in-serviced on resident rights and change of condition, and she was expected to contact the physician and to call 911 if a resident requested to go to the hospital. She stated LVN B called 911 and that was when EMS came to the facility to transport Resident #1 to the hospital. She stated the family did not call 911, and the facility staff called 911. In an interview on 01/14/2026 at 3:03 p.m., LVN B stated she entered Resident #1's room at approximately 7:15 a.m. after it was reported to her that Resident #1 was complaining of having shortness of breath. LVN B stated Resident #1 did request oxygen several times during the assessment. She stated the oxygen tank in Resident #1 was not working. LVN B stated Resident #1 became frustrated and anxious when she was assessing Resident #1. She stated Resident #1 continued to ask for oxygen. She stated she felt she was frustrating Resident #1 and was making Resident #1 worse due to her color becoming flushed and her becoming upset due to wanting oxygen. LVN B stated she did not call 911 or the physician. She stated she did not think it was necessary to contact the physician or call 911 until she finished her assessment. LVN B stated she re- entered Resident #1's room approximately 10 minutes later with an oxygen tank and placed the oxygen on Resident #1. She stated when she checked Resident #1's O2 sat, it was 94 percent at room air. LVN B stated after she placed the oxygen on Resident #1, she exited the room and asked ADON A to assess Resident #1. LVN B stated she asked Resident #1 if she wanted another nurse to give her care and she became upset after this question was asked of her. LVN B did not respond to why Resident #1 became upset after this question was asked. She stated Resident #1's family member called 911 for EMS to come to the facility and Resident #1 was transferred to the emergency room and was admitted to the hospital with shortness of breath and respiratory distress. LVN B stated if a resident requested for 911 to be called, and complained of shortness of breath, the facility was expected to call 911, the physician, and the family. She stated Resident #1's family member was on the phone when she was in the room. LVN B stated she did not have anything else to report about the situation with Resident #1. In an interview on 01/14/2026 at 4:00 p.m., the Director of Nurses stated anytime a resident was complaining about shortness of breath and requested for the nurse to call 911, her expectation was for the nurse to call 911 immediately. She stated Resident #1 did have a history of having shortness of breath and had heart conditions. Director of Nurses stated Resident #1 was placed on oxygen prior to EMS entering the facility. She stated that occurred on 01/13/2026 approximately 7:30 a.m. The Director of Nurses stated ADON A was in the room with Resident #1. She stated they were investigating exactly what occurred with Resident #1 on 01/13/2026. She stated ADON A needed to call 911 when the resident first stated she had shortness of breath and wanted 911 to be called instead of the family having to call 911. She stated it was the facility's responsibility to ensure the resident's wishes were honored and not neglect what Resident #1 was requesting. The Director of Nurses stated she would need to review the hospital records to determine Resident #1's condition when she arrived at the hospital to determine if it was an emergency for Resident #1 to be admitted to the hospital. She stated she would need to investigate more into the situation with Resident #1 before answering any further questions. Review of the facility's Change in a Resident's Condition or Status, dated 2016 , reflected Our facility (continued on next page)

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 01/29/2026
NAME OF PROVIDER OR SUPPLIER Accel at College Station		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Medical Avenue College Station, TX 77845	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediately to the nurse and if the nurse is the one observing the concern, the nurse was to immediately call the physician or 911 according to the circumstance of the resident. She stated quality of care meets professional standards and supports residents' highest level of well-being. The Director of Nurses stated when a resident had a change of condition this was when a new physical, mental or emotional change occurred, or an existing concern deteriorated. She stated the staff was expected to recognize the change, call the physician, report to the nurse, or call 911. She stated the resident was to be monitored until EMS came to the facility. The Director of Nurses stated delaying reporting can cause serious harm or delay calling 911. She stated if a resident refused care the nurse was to document it in the nurses notes.In an interview on 01/29/2026 at 3:30 pm the Administrator stated all staff except for 8 had been in-serviced on change of condition, resident rights and quality of care. She stated the 8 staff would not be eligible to work until they receive in-service. The Administrator stated ADON A was suspended on 01/28/2026. She stated they had a QAPI meeting and reviewed the POR and the concern with Quality of Care. The Administrator stated they had already began monitoring process such as the department heads make rounds on the residents they are assigned to and ensure there is no new or past issues with the residents. She stated in-services would be ongoing and anyone new would receive the in-service on resident rights, quality of care and change in condition prior to working at the facility. She stated the facility was continuing with their investigation of the situation with Resident #1. She stated the facility staff would randomly be monitored by the Director of Nurses or designee of their overall care for the r[TRUNCATED]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 of 4 residents (Resident #2) reviewed for infection control. 1. The facility failed, on 01/14/2026, to ensure RN C sanitized her hands prior to donning gloves while providing colostomy care to Resident #2.2. The facility failed, on 01/14/2026, to ensure RN C wore PPE (gown) while providing high contact resident care (colostomy care) to Resident #2. These failures could place residents at risk for infection and hospitalization.Findings include: Review of Resident #2's Face sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of sepsis, unspecified organism (a serious medical conditions characterized by the body's extreme response to an infection, where the specific organism causing the infection is not identified. It can lead to organ failure), perforation of intestine (a hole or tear in the intestinal wall, allowing digestive contents like food, bacteria, bile, and acid to leak into the abdominal cavity, causing severe infection and potentially life-threatening sepsis), colostomy status (a surgically created opening in the abdominal wall that connects the colon to the outside of the body, allowing waste to bypass a damaged or diseased part of the lower bowel), and malignant neoplasm of rectum (cancer forming in the tissues of the rectum). Review of Resident #2's MDS Assessment, dated 01/01/2026, reflected Resident #2 had a BIMS score of 13 indicated his cognition was intact. Resident #2 had a colostomy. He had diagnoses of septicemia (body's extreme response to an infection that enters the bloodstream) and sepsis. Review of Resident #2's Comprehensive Care Plan, revised on 01/07/2026, reflected Resident #2 had an ostomy secondary to bowel perforation. He was at risk for complications including but not limited to stoma (surgically created opening in the abdomen that allows bodily waste, such as urine or feces, to exit the body into a collection pouch, irritation and bleeding. Interventions: Colostomy care every shift as needed. Monitor for signs of infections such as edema, redness, increased pain around the stoma area. There was not a care plan for Resident #2 to be on enhance barrier precautions. Review of Resident #2's Physician Orders, revised on 01/07/2026, reflected enhanced barrier precautions related to colostomy/[NAME] drain (a surgical device with a tube and squeezable bulb that creates suction to remove excess blood and fluid from a surgical site, preventing infection and promoting healing). Observation on 01/16/2026 at 11:20 am, RN C was standing at the medication cart and was preparing the colostomy bag. She touched the scissors and the left side of her shirt. RN C did not wash her hands and touched the wafer of the colostomy (the skin barrier which is the sticky adhesive base that seals around the stoma to protect the skin from output and hold the pouch in place.) RN C exited the medication cart and walked down the hall to Resident #2's room. On the wall beside Resident #2's room (he did not have a roommate) was an enhance barrier precaution sign. RN C entered Resident #2' room without sanitizing hands, or donning gown. She donned gloves on her hands once she entered Resident #2's room but did not wash her hands. She touched the fourchettes of the gloves with her contaminated fingers and hands. RN C proceeded to change the colostomy and put in a new colostomy bag. In an interview on 01/16/2026 at 11:45 pm, RN C stated she did not sanitize her hands after she used the scissors at the medication cart, and she did touch the left side of her shirt. She stated she was expected to sanitize her hands prior to donning gloves. She stated the gloves were considered contaminated due to touching the outside of the gloves with her contaminated fingers and hands. RN C stated she did not have an excuse or reason she did not don a gown prior to entering Resident #2 room. She stated Resident #2 was on enhance (continued on next page)

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