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	04/08/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 resident (Resident # 1) of 7 residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 received sufficient supervision to avoid the fall which resulted in her right patellar fracture on 3/17/2026. The facility failed to ensure Resident #1 received adequate assistive devices to prevent Resident #1's right patellar fracture. This failure could result in residents experiencing accidents, injuries, unrelieved pain and diminished quality of life.Findings included: Review of Resident # 1's face sheet dated 4/8/2026 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: fracture of T11-T12 vertebra (a break in the bones at the very bottom of the mid-back, just above the waistline, often causing pain, loss of height, and stooped posture), dementia, history of falls, generalized muscle weakness, unsteadiness on feet, abnormal posture, cognitive communication deficit, fatigue, depression, and adjustment disorder with mixed anxiety and depressed mood. Review of Resident #1's admission MDS assessment dated [DATE] revealed her BIMS score was 1 indicating her cognition was severely impaired. The MDS also indicated Resident #1 required partial to moderate assistance to come to a standing position from sitting in a chair, wheelchair or on the side of the bed. She was dependent on staff to bend or stoop from a standing position to pick up a small object from the floor. Review of Resident #1's care plan initiated on 4/1/2026 revealed Resident #1 was a moderate risk for falls related to history of falls and impaired balance. The following interventions were initiated on 3/6/2026: be sure call light is within reach and encourage to use it for assistance as needed.; ensure a safe environment such as floors even and free from spills or clutter, adequate light, bed in low position, personal items within reach; and ensure that resident is wearing appropriate footwear (shoes, bedroom slippers, non-skid socks) when ambulating or up in w/c. The care plan revealed Resident #1 had a behavior problem related to impulsiveness with walking away without assistive device and not following verbal cues as evidenced by cognition impairment. The care plan revealed Resident #1 had a deficit in memory, judgement, decision making and thought process related to BIMS 1. The following interventions were initiated on 3/6/2026: ask yes or no questions in order to determine resident's needs; break activities into manageable subtasks; give one instruction at a time to resident; and explain each activity/care procedure prior to beginning it. The care plan revealed Resident #1 had an actual fall related to: poor balance and unsteady gait. The following interventions were initiated on 3/17/2026: when participating in balance exercises with therapy, the resident will use parallel bars moving forward; anticipate and meet needs; and reinforce the resident's need to call for assistance. Review of after-visit summary from [HOSPITAL ED] dated 3/17/2026 revealed a right knee x-ray was performed, and the resident was diagnosed with a patellar fracture. Review of physician progress notes dated 4/2/2026 revealed [Resident #1] sustained a right patella fracture from a fall and was evaluated in the ED; orthopedics recommended non-weightbearing on right leg with knee brace at all times. Resident #1 was able to participate in physical therapy. Requires.right knee brace in place and on at all times,.Generalized muscle weakness (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

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	04/08/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	present. Mobilizes with assistance as tolerated while braced. Weight-bearing status: WBAT (weight-bearing as tolerated) with knee in extension per orthopedics. Orthopedic follow-up with [doctor #1] at BSW clinic completed on 3/25/2026. [Resident #1] tolerating knee brace well. Fracture healing routinely. Pain controlled. Review of undated witness statement written by the DOR revealed on 3/17/2026 the therapy session involved a standing balance activity. This resident was standing with [PTA] present and holding onto [Resident #1's] gate[sic] belt for safety measures as the therapist was giving verbal instructions for specific movements. [Resident #1] reached to grab a ball, crossed one leg over the other and lost her balance, which caused her to fall to the floor, at this point the tech had to release the gait belt to avoid falling onto the resident. Review of undated witness statement written by the PTA revealed I was assisting.DOR in a standing balance activity with [Resident #1]. [Resident #1] crossed her legs and bent over to try to and grab a ball at that point she lost her balance and fell. Resident was wearing belt and verbal instructions were given to resident for safe technique. She ignored verbal instructions which led to the fall. Review of nursing progress notes dated 3/17/2026 at 11:10 am revealed [Resident #1] was in therapy gym engaging in a standing, ball catch exercise with Physical Therapist. Patient was standing with assistance from PT staff using a gait belt. Gait belt positioned correctly around patients [sic] torso while patient attempted exercise. Patient attempted to catch the ball, lost balance, and fell forward, landing on both knees followed by upper torso and face. Patient noted to be conscious and oriented. She was then positioned supine [lying flat on her back] on the floor and immediately assessed for injuries. Scant bleeding from left temple and verbalized complaints of bilateral knee pain. First aid applied to laceration to control bleeding. Vitals collected and [doctor #2] notified of incident who gave order to send patient to ER for evaluation via EMS. Patient remained in supine position on the floor while awaiting EMS arrival. Nursing staff remained continuously with the patient to ensure spinal safety, comfort, and monitoring of consciousness level until EMS arrived.Family present for incident. Review of physical therapy note dated 3/17/2026 by DOR revealed [Resident #1] participated in a balance activity, catching and throwing a ball. During the activity, rehab tech was assisting with pt balance.when [Resident #1] dropped ball. [Resident #1] was instructed to not pick ball up, however, [Resident #1] bent down to pick ball up, losing balance to the R. [Resident #1] left foot crossed over the right foot, and [Resident #1] fell to the floor. Rehab tech was holding gt belt, however, [Resident #1] was too far outside of BOS and experienced a fall. [Resident #1] c/o R knee pain. Nursing was notified, vitals were assessed, and pt remained on the floor until EMS arrived. Patient participated in coordination group and therapeutic exercise group with 6 patients with emphasis on the following goals/objectives: improve ability to participate in social/recreational activities, improve reaction time and overall precision of movement, improve ROM and strength to increase functional task performance, improve socialization skills and promote safety awareness during social/functional activities. [Resident #1] participated in education regarding safety awareness in the home. Review of occupational therapy note dated 3/18/2026 revealed barriers impacting treatment: .cognitive impairment. Review of physical therapy note dated 3/24/2026 revealed barriers impacting treatment: decreased attention skills, .exhibits heightened anxiety w/ activity, patient impulsivity, severe cognitive impairment. Review of fall incidents with a date range of 3/1/2026 - 4/8/2026 for 8 residents revealed no other residents experienced injuries due to falls while performing physical therapy. Review of PTA training dated 3/25/2025 revealed he was able to demonstrate competencies with the following: gait belt use during transfer of a resident; moving residents in bed; and moving residents in bed using a lift. Review of PTA training dated 4/7/2025 revealed he was trained on the following: how to transfer a resident from the bed to a wheelchair with a gait belt, and how to assist a resident to ambulate with a gait belt. Review of PTA training check list dated 4/25/2025 revealed he received training on balance guarding, gait belts, and lower and upper extremity therapy exercises. Review of in-service dated 3/17/2026 revealed therapy staff including the PTA were in-serviced on transfers and fall prevention. Review of Occupational Safety and Health Administration's Ergonomics (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676437	A. Building B. Wing	04/08/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Guidelines competencies dated 3/19/2026 revealed therapy staff demonstrated proper techniques in the following areas: transferring a resident from bed to chair; repositioning a resident in bed and chair; and demonstrating how to lift and transfer a resident using mechanical lift equipment. Review of grievance/complaint report dated 3/18/2026 revealed family member had concerns of types of therapy exercises. A group meeting was held with DOR, administrator and family member. The DOR gave explanation and benefits of therapy conducted. Therapy staff were in-serviced on safe transfers and fall prevention. Observation on 4/8/2026 at 10:01 am reflected Resident #1 was sitting in a chair with both of her legs extended onto a chair with a pillow underneath them. She had a clam shell brace on and was watching television with her personal LVN caregiver present. Resident #1 was smiling and appeared comfortable. Resident #1 was unable to give me details about her fall. Her personal LVN caregiver stated, she has dementia and probably does not remember. Observation on 4/8/2026 at 10:53 am reflected multiple residents were sitting in a circle with a restorative aide. The restorative aide instructed the residents to extend their legs and bring them back to resting position. The residents had gait belts around their waists and were participating in the activity. There was another therapy staff member who was walking around the residents, and encouraging them during the activity. In an interview on 4/8/2026 at 11:47 am, Resident #1's personal LVN caregiver reported she was in the gym observing Resident #1 engaged in physical therapy. She stated the main goal has been teaching her to keep both hands on the walker. She reported Resident #1 and another resident were throwing a large ball to each other. She reported both residents had physical therapy staff standing by and holding their gait belts with their walkers in front of them. She reported the other resident bounced the ball toward the left of Resident #1. She stated, [Resident #1] reached for the ball without stepping, and fell down on her right knee and head. She reported Resident #1's glasses broke during the fall which resulted in a cut on her forehead. She reported staff turned Resident #1 on her back since blood was dripping across her face. She stated Resident #1 moaned, and attempted to touch her knee. She denied being able to describe the PTA's movements after the fall and stated, I was focused on her falling. I didn't notice what he did. She reported two nurses assessed Resident #1 in the gym, called EMS, and stayed with her until they arrived. In an interview on 4/8/2026 at 12:55 pm, the PTA reported he was doing a balance training activity with 2 residents. He assisted Resident #1 while the director of rehabilitation assisted the other resident. He stated, we told her not to be reaching or bend to get the ball if it bounces away from her. He reported the other resident bounced the ball to Resident #1. He stated [Resident #1] started to go down and my gait belt slipped out. I was holding her properly because I had my hand inside the belt. He reported Resident #1's walker was in front of her and her wheelchair was behind her. He stated, I had to let go or I would have fallen on top of her. In an interview on 4/8/2026 at 1:10 pm, the DOR reported she has worked at the facility for about 2 years. She reported she was doing a catch and throw reactive balance activity with Resident #1 and another resident. She stated, we told [Resident #1] not to bend down to catch the ball, just let it go. She reported Resident #1 followed the directions whenever they instructed her not to bend or reach for the ball prior to her fall. She stated on the second pass she bent down towards the right, her foot crossed over, and she was so out of base there was no recovering. She had a fall. She reported the PTA was standing to the left of Resident #1, and the wheelchair was behind Resident #1. She reported Resident #1 often walks without using an assistive device so they were trying to improve her dynamic active balance with the activity. She stated, in hindsight, we should have done it by the parallel bars. She reported she had not worked with Resident #1 since her fall. She stated, she is ambulating 100 feet, and doing balance activities with contact guard assist. She reported Resident #1 was able to maintain her balance whenever they performed the catch and throw activity before the incident. She stated Resident #1 was able to follow their instructions when they would instruct her not to bend or reach for the ball. She reported the fall could have been prevented by doing the activity with therapy bars, and stated, we have done the activity at the parallel bars since the incident. She reported she trained the PTA. In an interview on 4/8/2026 at 2:34 pm, the PT reported she was not at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676437	A. Building B. Wing	04/08/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	work on the day Resident #1 fell. She reported Resident #1 was unable to follow directions consistently. She stated, I wrote goals for balance and they were working with her for that. She stated, I feel it is an appropriate activity for her. She stated, it was something I would do with her as a balance activity. She reported her expectation for the physical therapy staff was for them to instruct the resident on what to do or not to do prior to an activity. She stated, the expectation is they have a gait belt and hands on it during activities. She stated, I write the [therapy] plans and the staff chooses the activity within the scope of what was written. In an interview on 4/8/2026 at 3:05 pm, the administrator reported he has worked at the facility since 3/30/2026. He stated, the way the situation was described to me at the time, when [Resident #1] slipped, she lost her grip when she was told not to do. He reported the fall resulted in a broken knee. In an interview on 4/8/2026 at 4:35 pm, the administrator stated, when they come to our facility, our goal is prior level of functioning. We allow the family to set the goals. That is also important. Safety is extremely important. We want to avoid any injury in the gym. Accidents happen, but that is not an excuse. We need to increase interventions for safety. He reported the therapy staff immediately report to the DOR. Review of safe lifting and movement of residents' policy with a revision date of 7/2017 revealed Policy Statement In order to protect the safety and wellbeing of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis.Such assessment shall include: 2. Resident's mobility (degree of dependency).5. Cognitive status; 6. Whether the resident is usually cooperative with staff; and 7. The resident's goals for rehabilitation, including restoring or maintaining functional abilities. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. Review of the facility's fall clinical protocol with a revision date of 9/2012 revealed Treatment/Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.2) If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance. Monitoring and Follow-up.2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented. 3. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention (for example, dizziness or musculoskeletal pain) has resolved. 4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions.