

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents remained free of any significant errors for one of four residents (Resident #1) reviewed for medications and pharmacy services. The facility failed to ensure the physician's orders were followed for Resident #1 when MA A administered 3 different medications that could affect the heart when the orders stated to hold the medications for heart rate/pulse less than 60 and Resident #1's heart rate was documented to be less than 60 on 06/19/2026 and 06/20/2026. This failure could place residents at risk of not receiving the intended therapeutic benefits of the medication and symptomatic changes in vital signs. Findings included: Review of Resident #1's admission record, dated 07/08/2026, reflected a [AGE] year-old female, admitted to the facility on [DATE] and discharged on 06/21/2026 with diagnoses that included Unspecified fall, essential hypertension (high blood pressure), and paroxysmal atrial fibrillation (the heart suddenly starts beating irregularly and fast, but goes back to beating normally on its own again). Review of Resident #1's Comprehensive MDS, dated [DATE], reflected a BIMS score was 99 which indicated she was unable to complete the BIMS assessment. The staff assessment for mental status reflected she had short-term and long-term memory problems. Section I - Active Diagnoses reflected Resident #1 had hypertension and atrial fibrillation (an irregular heart rhythm). Review of Resident #1's care plan, dated 06/08/2026, revealed no documentation related to high blood pressure or atrial fibrillation. Review of Resident #1's Medication Administration Record for June 2026 reflected: Amiodarone Hcl [a medication used to prevent and treat fast or irregular heartbeats] Oral Tablet 200 MG Give 1 tablet by mouth one time a day for Arrhythmia [irregular heart rhythm] hold if pulse less than 60 with a start date of 06/17/2026. The June 2026 medication administration record reflected MA A administered Amiodarone on 06/20/2026 with Resident #1's pulse documented as 43. Metoprolol Succinate ER [a slow-release medication used to treat heart rhythm disorders and high blood pressure] Oral Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN hold if sbp [top number in the blood pressure] is less than 110 or hr less than 60 with a start date of 05/21/2026. The June 2026 medication administration record reflected MA A administered Metoprolol on 06/19/2026 with Resident #1's heart rate documented as 43. It reflected MA A administered Metoprolol on 06/20/2026 with Resident #1's heart rate documented as 43. Lisinopril [a medication administered for the treatment of high blood pressure] Oral tablet 10 MG Give 1 tablet by mouth two times a day for HTN hold if sbp is less than 110 or hr less than 60 with a start date of 05/20/2026. The June 2026 medication administration record reflected MA A administered a dose on 06/19/2026 between 6 AM - 1 PM to Resident #1 with a documented heart rate of 43. She administered a dose on 06/20/2026 between 6 AM - 1 PM with Resident #1's documented heart rate of 43. MA A administered a dose of Lisinopril on 06/20/2026 between 6 AM - 1 PM with Resident #1's documented heart rate was 56. Review of Resident #1's (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	documented heart rates/pulses for June 2026 reflected the following: 06/19/2026 08:01 AM - 43 bpm documented by MA A;06/19/2026 08:11 AM - 46 bpm documented by RN C;06/19/2026 02:32 PM - 54 bpm documented by RN C;06/19/2026 05:58 PM - 67 bpm documented by MA A;06/19/2026 06:00 PM - 55 bpm documented by RN C;06/20/2026 09:10 AM - 43 bpm documented by MA A;06/20/2026 09:11 AM - 43 bpm documented by MA A;06/20/2026 09:11 AM - 43 bpm documented by MA A;06/20/2026 05:05 PM - 56 bpm documented by MA A;06/21/2026 08:22 AM - 60 bpm documented by MA A. Review of Resident #1's order summary, dated 07/08/2026, for active orders as of 06/21/2026, reflected the following: Amiodarone HCl Oral Tablet 200 MG Give 1 tablet by mouth one time a day for Arrhythmia hold if pulse less than 60 with a start dated of 06/17/2026; Lisinopril Oral Tablet 10 MG Give 1 tablet by mouth two times a day for HTN hold if sbp is less than 110 or hr less than 60 with a start date of 05/20/2026; and Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN hold if sbp is less than 110 or hr less than 60 with a start date of 05/21/2026. During an interview on 07/09/2026 at 09:15 AM, MA A stated she had been trained to administer medication. She stated her last training was in June 2026. She stated she was trained to follow the seven rights of medications administration. MA A stated she was trained to check the resident's vital signs first, if indicated, and if the vital signs were out of range, then she was expected to hold the medication and report it to the charge nurse right away. MA A stated the staff member administering medication was responsible for assessing the vital signs first. She stated if the medication was required to be held due to the parameters set forth by the doctor, then she would have the nurse do an assessment and administer the medication, if necessary. MA A stated if the medication was administered to the resident even if the vital signs were outside of the parameter, then their heartrate could bottom out and the resident could pass out. She stated on 6/19/2026 she assessed Resident #1's vital signs and her heartrate was 43. She stated she documented the heart rate but did not know how to document the medication was not administered but still document the vital signs so she signed it off as administered, but she told the RN C the vital signs and gave her the medication so that she could reassess Resident #1's vital signs and RN C could administer the medications, if necessary. She stated the same thing happened on 06/20/2026 two different times, both in the morning and the afternoon. MA A stated she held all the medications with parameters on 6/19/2026 and 6/20/2026 due to the low heart rate. She stated she did prepare the medications each time, but she did not administer the medication. She stated she handed the medications to RN C. She stated she documented the notification to RN C on 6/19/2026 but she forgot to write a progress note on 6/20/2026 stating that she notified RN C. During an interview on 07/09/2026 at 09:34 AM, RN C stated she had been trained to administer medications. She stated her last in-service related to medication administration was in May 2026. She stated it was the facility's policy to check the blood pressure and heart rate prior to administering medication that could affect the heart. RN C stated the medications that affect the heart had parameters to hold for a systolic blood pressure less than 110 and/or a heart rate less than 60. She stated the medication aide was responsible for holding the medication and notifying the nurse if the resident's blood pressure or heart rate were not within the parameters. RN C stated she would then be responsible to reassess the resident's blood pressure and heart rate. She stated the medication aide was responsible for documenting the medication was held and the nurse was notified and the nurse was responsible for documenting the reassessment of the blood pressure and heart rate and, if necessary because the reassessment revealed the heart rate and/or blood pressure were out of range, the notification of the doctor. RN C stated if the medications were not held and the blood pressure and/or heart rate were outside of the parameters, then the blood pressure and/or heart rate to drop. RN C reviewed the electronic health record for Resident #1 on (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	06/19/2026 and 06/20/2026 and stated she did not remember MA A notifying her of the low heart rate on 06/19/2026, but she performed a reassessment of her heart rate 10 minutes after MA A did an assessment, so she must have been aware of the heart rate. She stated she did not document that she notified the doctor or nurse practitioner about the low heart rate, so she was not sure if she did or not. She stated she was not told on 06/19/2026 that the medications with parameters were administered. RN C stated she was not notified on 06/20/2026 that Resident #1's heart rate was 43 or that it was 56 or that any medications were held on that day. She stated if she had been notified, she would have documented the reassessment of the heart rate when she did it. During an interview on 07/09/2026 at 10:25 AM, the NP stated she could not recall if she was notified about Resident #1's heart rate on 06/19/2026 and 06/20/2026. She stated the practice she worked for ensured standing orders were placed for medications that affected the heart. She stated anything outside of the parameters she expected the medication to be held. She stated if the medication was not held then the resident could experience low blood pressure. During an interview on 07/09/2026 at 12:26 PM, the MD stated he was aware that Resident #1's heart rate/pulse would drop into the 40's and her medications were being adjusted. He stated for a heart rate under 60 he would have recommended holding the Amiodarone, but he would not have held the Lisinopril for the heart rate alone. During an interview on 07/09/2026 at 04:23 PM, the DON stated the facility's policy for administering medication that affected the heart was to check the blood pressure and heart rate prior to administering the medication and hold the medication if the heart rate or blood pressure was not within the parameters. She stated the medication aide was responsible for checking the blood pressure and heart rate and the charge nurse was responsible for reassessing the blood pressure and heart rate. The DON stated she expected the medication aide to notify the charge nurse. She stated the charge nurse was responsible for notifying the doctor or nurse practitioner if the charge nurse's assessment revealed the blood pressure or heart rate was not within the parameters on the order. She stated she expected the medication aide to document on the medication administration record and in the progress notes if the medication was held because of the parameters. She stated if a medication that affects the heart is administered even though the blood pressure and/or heart rate were not within parameters, then the residents heart rate and/or blood pressure could drop even lower. During an interview on 07/09/2026 at 05:57 PM, the ADM stated he expected the medication aides to notify the charge nurse if the residents vital signs are outside of the parameters ordered by the provider. He stated he would then expect the charge nurse to notify the provider of the vital sign that was not within the parameter. Review of facility policy titled Administering Oral Medications, dated 2001 and revised October 2010, reflected, Purpose The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Steps in the Procedure. 13. Perform any pre-administration assessments. Reporting. 2. Report other information in accordance with facility policy and professional standards of practice.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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, interview, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of needs and preferences for two of eight (Resident #2 and Resident #3) residents reviewed for reasonable accommodation of needs. The facility failed to ensure RN B was not on her cell phone while sitting at the dining room table with Resident #2 and Resident #3 during breakfast on 07/08/2026. This failure had the potential to place all residents at risk of not having their needs met timely and decreased dignity. Findings included: Resident #2 Record review of Resident #2's admission record, dated 07/08/2026, reflected an [AGE] year-old female, admitted to the facility on [DATE], with diagnoses that included unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), lack of coordination, and dysphagia (difficulty swallowing). Record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 00, which indicated severe cognitive impairment. Section GG - Functional Abilities reflected Resident #2 required Supervision or touching assistance for eating. Record review of Resident #2's care plan, dated 04/30/2024 and last revised on 06/07/2026, reflected a focus of [Resident #2] has an ADL Self Care Performance Deficit r/t Dementia with interventions that included EATING: The resident requires (x 1) staff participation to eat. Resident #3 Record review of Resident #3's admission record, dated 07/08/2026, reflected a [AGE] year-old female, admitted to the facility on [DATE] and most recently readmitted on [DATE], with diagnoses that included dysphagia, oropharyngeal phase (difficulty swallowing), unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), and cognitive communication deficit (problems with communication). Record review of Resident #3's Comprehensive MDS, dated [DATE], reflected a BIMS score of 00, which indicated severe cognitive impairment. Section GG - Functional Abilities reflected Resident #3 required Substantial/maximal assistance for eating. Record review of Resident #3's care plan, dated 03/19/2019 and last revised on 07/07/2026, reflected a focus of [Resident #3] Exhibits ADL Self Care Performance Deficit, requires assistance; cognitive deficit secondary to dementia disease progression with interventions that included Eating: requires extensive assist x 1 staff participation assist. During an observation on 07/08/2026 at 08:13 AM revealed RN B was sitting at the dining room table looking at the screen of her cellular phone. Resident #2 was sitting at the table to the left of RN B with her breakfast plate in front of her and Resident #3 was sitting at the table to the right of RN B with her breakfast plate in front of her. Attempted to interview RN B at 07/08/2026 at 08:13 AM and she stated she was tired and walked away. During an interview on 07/09/2026 at 04:23 PM, the DON stated the facility's policy for cellular phone use at the facility was that the staff were not allowed to use their personal cellular phones in patient care areas. She stated the nurse was allowed to use her personal cellular phone to contact the doctor or nurse practitioner, but they needed to step away from the residents. The DON stated she had a talk with RN B and RN B reported that she was listening to music on her phone in the dining room. She stated personal cellular phones were not allowed to be used in resident care areas because it may make the residents feel like the staff's cellular phone was more important than the residents. During an interview on 07/09/2026 at 05:57 PM, the ADM stated the facility's policy for cellular phone use by employees at the facility was staff were not allowed to use their personal cellular phones in patient care areas. He stated staff would not be able to supervise the residents if (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	they are on their phones. The ADM stated if staff were on their cellular phones, then residents might get irritated and feel like their phones are more important than the residents. Review of an unnamed facility policy, dated 04/2019, reflected 10.3 COUNSELING: In all cases regarding the application of discipline, constructive counseling will be used, as necessary, to inform you of the nature of the infraction, the form of corrective action needed to improve, and the likely consequence of your failure to correct the misconduct, or if you continue to repeat the misconduct. You will receive copies of all disciplinary actions, with originals kept in your personnel file. The following is a general outline providing examples of employee violations subject to disciplinary measures: .Personal Cell phone use while on duty.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 5 (200-hall nurse cart) medication carts reviewed for drug storage and labeling. The facility failed to ensure the 200-hall nurse cart was locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings include: During an observation of the area between the nurses' station and the dining room on 07/08/2026 at 08:12 AM, revealed RN B was sitting at a dining room table with 2 residents. Her nurse medication cart was positioned up against the wall that divided the nurse's station from the dining room, and was unlocked, the locking mechanism was left sticking out. Staff and residents were observed walking past the unlocked medication cart. During an interview on 07/08/2026 at 08:13 AM, RN B stated she was responsible for the 200-hall nurse cart. She stated the policy for medication storage was to ensure all medication carts were locked at all times. She stated she forgot to lock the cart because she got distracted with helping residents with breakfast. She stated it was required to keep the medication carts locked because the residents could get into the cart and take something that could make them sick. During an interview on 07/09/2026 at 04:23 PM, the DON stated the policy for medication storage was to secure the cart with a lock anytime the cart was not in use. She stated it was the responsibility of the person who had the keys for the medication cart to lock the cart. She stated all staff were responsible for monitoring to ensure the medication carts were locked by observing during their rounds. The DON stated if the medication cart was left unlocked and unattended then a resident could get into the cart and take something they were allergic to. During an interview on 07/09/2026 at 05:57 PM, the ADM stated the policy for medication storage in the medication cart was to lock the medication cart when not in use. He stated the person with the keys to the cart was responsible for ensuring the cart was locked before they left it unattended. The ADM stated nursing management was responsible for monitoring to ensure the medication carts were locked when they did their rounds. He stated if the cart were left unlocked then a resident or family member could take something out of the medication cart and it would possibly cause a drug diversion. Review of facility policy titled Storage of Medications, dated 2001 and last revised April 2007, reflected Policy Statement The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation. 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure weekly skin assessments were accurately documented for 1 of 8 (Resident #1) residents reviewed for skin assessments. The facility failed to ensure LVN D provided accurate documentation of skin assessments when she documented a skin assessment on Resident #1 on 06/23/2026. Resident #1 was discharged to the hospital on [DATE], had not returned and was not in the facility on 06/23/2026. This failure could place residents at risk of worsening skin issues, infection, and not receiving appropriate care. Findings included: Review of Resident #1's admission record, dated 07/08/2026, reflected a [AGE] year-old female, admitted to the facility on [DATE] and discharged on 06/21/2026 with diagnoses that included Unspecified fall, essential hypertension (high blood pressure), and paroxysmal atrial fibrillation (the heart suddenly starts beating irregularly and fast, but goes back to beating normally on its own again). Review of Resident #1's Comprehensive MDS, dated [DATE], reflected a BIMS score was 99 which indicated she was unable to complete the BIMS assessment. The staff assessment for mental status reflected she had short-term and long-term memory problems. Review of Resident #1's care plan, dated 05/21/2026, reflected a focus of [Resident #1] has actual impairment to skin integrity r/t surgical wound at R medial [inner] knee and interventions that included Observe skin injury for abnormalities, failure to heal, s/sx of infection, maceration [skin damage due to prolonged exposure to liquid] etc. and report to MD. During an interview and record review on 07/09/2026 at 03:43 PM, LVN D stated she was responsible for completing the weekly skin assessment and documenting them in the electronic health record. She stated she completed the skin assessment for Resident #1 on 06/23/2026 after reviewing the electronic health record. Record review of the skin assessment, dated 06/23/2026, reflected Resident #1 had bruising to her bilateral upper extremities (arm) and bilateral lower extremities (legs). She stated she apparently just clicked the bubbles and went on to the next resident when asked how she completed the skin assessment for Resident #1 after she was discharged from the facility on 06/21/2026. LVN D stated she was overwhelmed with completing her assignments and so she just completed the weekly skin assessment in the electronic health record. She stated she did the physical skin assessment the week prior on an unknown day but documented it on 06/23/2026. LVN D stated documenting skin assessments days after they were completed could affect the residents because they could develop a new skin issue and it would be unknown when the skin issue actually occurred. During an interview on 07/09/2026 at 04:23 PM, the DON stated the facility's policy for skin assessments was for the charge nurse to do a skin assessment upon admission and LVN D was responsible for the weekly skin assessments after admission. She stated she expected the weekly skin assessments to be performed and documented every 7 days or as soon as the resident is available. She stated she expected LVN D to document her assessments when they were performed and not at a later date. She stated if an assessment was not documented when it was performed then a new skin issue could arise that would not be identified. During an interview on 07/09/2026 at 05:57 AM, the ADM stated he expected LVN D to do skin assessments regularly. He stated he was unsure how often they were required to be completed. He stated he had previously had discussions with LVN D about her work responsibilities and had adjusted her other responsibilities and granted overtime to allow LVN D the resources to complete her work responsibilities. He stated there were a lot of variables that needed to be considered to determine how a resident could be affected if a skin assessment was documented but was not actually performed at that time. Review of (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy titled Pressure Ulcer Risk Assessment, dated 2001 and last revised March 2005, reflected Purpose. The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. General Guidelines. 10. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor. Assessment. 2. Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 3. Monitoring. c. Nurses will conduct skin assessments at least weekly to identify changes. Step in the Procedure. 5. Document the procedure.		