

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

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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 07/27/2026
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and resident's representative(s) of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 (Resident #1) of 4 residents reviewed for discharge planning. 1. The facility failed to inform Resident #1's FM about his discharge to another facility on 06/04/2026. 2. The facility failed to inform the Ombudsman of Resident #1's discharge on [DATE] to another facility. This failure could place residents at risk of not receiving care and services to meet their needs at discharge to the other facility due to the receiving facility not getting Resident #1's medications, and diet orders. Findings included: Record review of Resident #1's face sheet dated 07/27/2026 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included sepsis (a life-threatening complication of an infection), cholecystitis (inflammation of the gallbladder), heart failure, cerebral infraction (stroke), lack of coordination, muscle weakness, and end stage renal disease (kidney failure). Record review of Resident #1's discharge MDS dated [DATE] revealed Resident #1 had a BIMS score of 09, which indicated moderate cognitive impairment. Record review of Resident #1's care plan dated 05/21/2026 revealed Resident #1 did not have any information on discharge planning. Record review of Resident #1's medical records revealed Resident #1's payor source was commercial insurance. During an interview with the Ombudsman on 07/27/2026 at 8:54a.m., she said she did not know about Resident #1 being discharged . She also said she did not get a 30-day notice for Resident #1. She said that Resident #1's FM told her that she did not know Resident #1 was discharged . She said the facility did not send any paperwork or medication with Resident #1 from what Resident #1's FM told her. During an interview with Resident #1's FM on 07/27/2026 at 10:11a.m., she said the facility told her they were not an SSI pending facility. She said on 05/20/2026 the SW texted her with a list of facilities in the area that were SSI pending. She said that the facility sent her a text message on 06/04/2026 saying they were transferring Resident #1 that day to a facility out of the area. She said when she talked to the SW through text she was told that he would not be transferred to the other facility. She said when she went to the facility on [DATE] Resident #1 was not there, and staff told her he was transferred. During an interview with the SW on 07/27/2026 at 11:20a.m., she said that Resident #1 and his FM wanted to switch to long term care. She said Resident #1 wanted the FM to take care of everything. She said a lot of the facilities she tried to get Resident #1 into had denied him. She said she contacted the FM about the out-of-town facility that accepted Resident #1. She said she informed the FM he would be moved that day. She said later that day the facility informed her that he would not be accepted because the facility did not want to transport the resident to dialysis. She said she canceled (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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