STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission for 3 (Resident #3, Resident #13, Resident #30) of 5 residents reviewed for care planning.1.The facility failed to accurately complete the Physician Orders section on the baseline care plan, to indicate Resident #3 was being admitted to the facility with psychotropic medications.2.The facility failed to have a baseline care plan for Resident # 13 and Resident #30 This failure could place newly admitted residents at risk of not having their needs met, not receiving appropriate medications, not receiving necessary treatments, resulting in poor quality of life. 1) Record review of Resident #3's admission MDS Assessment, dated 7/31/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnosis of anxiety disorder. The resident BIMS score was 11 indicating moderately impaired cognition. Section E reflected none of the above for potential indicators of psychosis and no behavioral symptoms. Section N reflected Resident #3 was admitted with Antipsychotic Medication and indication noted. Review of Resident #3's Admit Baseline Care Plan dated 7/28/25 under Physician Orders/Medications/Treatments reflected Resident had no psychotropic therapy. Record review of Resident #3 Physician's Orders dated 7/28/25 reflected Quetiapine Fumarate 50mg tablet (QUEtiapine Fumarate) for G47.00 Insomnia, unspecified ([Start 7/28/25 18:34] 1 tablet by mouth at Bedtime). Record review of Resident #3's Medication Record for 8/1/25 - 8/31/25 reflected administration of Quetiapine Fumarate as ordered each day. 2) Record review of Resident #13's face sheet dated 08/21/2025 reflected she was a [AGE] year-old female with an original admission date of 07/18/2025. Record review of Resident #13's care plan revealed she did not have a baseline care plan.3) Record review of Resident #30s MDS dated [DATE] reflected he was an [AGE] year-old male with an admission date of 07/30/2025, BIMS score of 09 indicated moderate cognitive impairment. His diagnoses included Chronic Obstructive Pulmonary Disease (breathing difficulty).Record review of Resident #30's care plan revealed he did not have a baseline care plan. Interview with the MDS Coordinator on 8/21/25 at 2:35pm revealed she did not complete baseline care plans; she stated the nurse who admitted the resident was responsible for completing the baseline care plan. The risk of not having completed the baseline care plan accurately would be the staff would not know how to provide accurate care and interventions to the resident when they are admitted . Interview with LVN E on 8/21/25 at 3:25pm revealed nurses are responsible for completion of the baseline care plan. LVN E stated the nurses had 24-72 hours to complete a resident's admission which included the baseline care plan. LVN E stated she answered questions on the baseline care plan using notes and residents' assessments. If a resident arrived at the facility with psychotropic medication they would mark psychotropic therapy on the baseline care plan. Seroquel would be considered psychotropic medication and therefore psychotropic therapy would be check marked on the baseline care plan. The risk of not identifying psychotropic medications on the baseline care plan would be all staff wouldn't know what the resident's needs were and wouldn't know to monitor the side effects and behaviors. Interview with the DON on 8/21/25 at 4:09pm revealed nurses were responsible for the completion of baseline care plans. The DON stated they got a new electronic record's system on 7/22/25 and the nurses had been struggling to complete the baseline care plan efficiently. The DON reported he was working with nurses' side by side to help teach them the new system. The facility also had super users in the building that helped with major issues with the system. Regarding Resident #3's baseline care plan, Psychotropic therapy should have been checked off for the resident due to him being prescribed Seroquel. The risk of not noting the psychotropic therapy on the baseline care plan was it could have impeded the resident's treatment plan. The DON stated he was unsure of the reason psychotropic medication was not marked on Resident #3's baseline care plan. Review of the facility's policy Person Centered Care Plans revised 6/25/22 reflected .1. The facility must develop and implement a baseline person-centered care plan that meets professional standards of quality care. The baseline care plan will consist of the following: 2. Be developed within 48 hours of a resident's admission. 3. Include the minimum healthcare information necessary to properly care for a resident including but not limited to:.b. physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 6 residents (Residents #66, #38) reviewed for care plans.1. The facility failed to develop the following comprehensive person-centered care plans for Resident #66: playing music calmed her her representative preferred her nightstand lamp to stay on at night the need for bilateral (left and right) palm guards due to hand contractures.2. The facility failed to develop a comprehensive person-center care plan that reflected Resident #38 preferred to have her medication placed in her hand, one at a time, during medication administration due to being legally blind. These deficient practices could place residents at risk of not receiving the necessary care or services.Findings included:1. Record review of Resident #66 Quarterly MDS assessment, dated 07/20/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (loss of cognition), anxiety (feelings of intense worry), and depression (feelings of sadness/loss of interest). Review of Section N- Medications- N0415. High-Risk Drug Classes- reflected she was taking antipsychotic, antianxiety, and an antidepressant. N0450. Antipsychotic Medication Review reflected the resident received antipsychotic medications on a routine basis and a gradual dose reduction (GDR) had not been attempted, the physician had not documented the GDR as clinical contraindicated. Review of Section O- Special Treatments, Procedures, and Programs reflected there were no days of restorative programs performed for a splint or brace assistance.Record review of Resident #66's care plan, printed 08/19/25, reflected she was a fall risk related to contractures and paralysis with an onset date of 10/07/24, and reviewed and continued 05/06/25. Interventions included anticipate resident's needs, check frequently, low bed, and therapy referral. Review of the care plan revealed no documentation that playing music calmed Resident #66. Review revealed no documentation that Resident #66's representative preferred Resident #66's nightstand lamp to stay on at night. Review of the care plan revealed no documentation that Resident #66 required bilateral (left and right) palm guards due to hand contractures. Record review of Resident #66's Kardex, printed 08/19/25, reflected blank spaces for what the resident enjoyed to do, what made life meaningful to the resident, and contracture devices. Record review of Resident #66's physician orders, printed 08/21/25, reflected no orders for palm guards or contracture devices. In an observation on 08/19/25 at 10:19 AM of Resident #66, she was asleep in bed on the lowest position with music playing from a music player on her nightstand next to her bed wearing a palm guard to her left hand. There was a sign on the wall that reflected: Music calms her-helps if she is yelling turn CD player on and a sign on the lamp on her nightstand that reflected: please leave light on at night, thank you. In an interview on 08/19/25 at 1:23 PM with Resident #66's representative, she stated she had put up the signs to ensure staff were aware of what helped Resident #66 to be calmer and the staff were good about following the interventions. She stated she participated in care plan meetings. She stated she was not sure if it was something they discussed during the care plan meetings. She stated she frequently visited Resident #66 and saw that staff were aware of the Resident's needs.An observation on 08/20/25 at 12:05 PM revealed Resident #66 was lying in bed and mumbling incoherently and was wearing a palm guard to her left hand. An interview on 08/20/25 at 12:10 PM with MA J revealed Resident #66 was not able to communicate coherently and sometimes yelled out in agitation. MA J stated Resident #66 was calmed when they played music that was on her nightstand, and she was aware because of the signs posted in Resident #66 room by the representative. She stated she was not sure if Resident #66's music and lamp light staying on at night, or palm guard were care planned. She stated she knew of Resident #66's interventions because of the signs in her room. She stated staff were informed during change of shift of residents needs and she was able to see the Kardex and Medication Administration Record (MAR).An interview on 08/21/25 at 9:09 AM with CNA H revealed Resident #66 had on a palm guard to her left hand and none on her right hand. Observation of Resident #66's right and left hands with CNA H revealed her nails were trimmed with no jagged areas and the skin of her palms had no injuries. CNA H stated that the CNAs only had access to the Kardex and if there were resident preferences, CNAs were informed by nursing management or during change of shift and could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interviews, the facility failed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 of 5 residents (Resident #3) reviewed for care plan development. The facility failed to complete Resident #3's comprehensive care plan in a timely manner after his comprehensive assessment was completed. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs.Record review of Resident #3's admission MDS Assessment, dated 7/31/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] . Resident #3 had the following diagnoses: Anxiety Disorder, Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood circulation), Heart Failure, Diabetes and Asthma. Section M reflected resident was developing a pressure ulcer. Resident was admitted with the following medications: Antipsychotic, Anticoagulant (blood thinner), Antibiotic, Diuretic and Hypoglycemic (including insulin). Section O reflected resident needed continuous oxygen. Record review of Resident #3's Admit Baseline Care Plan reflected a completion date of 7/28/25.Record request for Resident #3's Comprehensive Care Plan on 8/21/25 at 2:04pm revealed he did not have one completed.Interview with the MDS Coordinator on 8/21/25 at 2:35pm revealed she was responsible for the completion of the Comprehensive Care Plan. The MDS Coordinator stated the expectation was she completed the MDS first and the Comprehensive Care plan would have been completed within 14 calendar days after the resident admitted to the facility. The MDS Coordinator stated she overlooked the care plan for Resident #3 and had not completed his comprehensive care plan yet. The MDS Coordinator stated she would used the CAA, notes from physician, nurses' notes and physician orders to complete the Comprehensive Care Plan. The MDS Coordinator stated psychotropic medications would be on the Comprehensive Care Plan, along with behavioral monitoring and monitoring of side effects. The risk to the resident of not having a comprehensive care plan in a timely manner was staff would not know how to provide accurate care and interventions. The MDS Coordinator completed the following trainings: RAI and Care Planning. The MDS Coordinator also referred to regional resources and trainings when she had questions on completion of the Care Plans. She stated the training for Care Planning was ongoing. Interview with LVN E on 8/21/25 at 3:25pm revealed the MDS Nurse or Unit Manager created and updated care plans. Nurses did not complete care plans. Interview with the DON on 8/21/25 at 4:09 pm revealed the comprehensive care plan was due 21 days from admission. The countdown started from the first day of admission and was calendar days. The nurses were responsible for acute comprehensive care plans, but the CAA triggers were completed by the MDS nurse. He stated Resident #3 should have had his comprehensive care plan completed already. The risk of not having had the care plan done would be it could impede the resident's treatment. He was unsure of the reason the care plan had not been completed. Interview with the Administrator on 8/21/25 at 4:49 pm revealed the expectation was the MDS nurse or nursing staff completed the care plans. The risk to the resident of not having a completed care plan was a lot of things could have gotten messed up and affected the resident negatively. Review of the facility's policy Person Centered Care Plans revised 6/25/22 reflected . Standard of Practice: Each resident will have a person-centered care plan developed and implemented to meet his or her other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.9. Comprehensive Care Plan - must be developed within seven (7) days after completion of the comprehensive assessment, quarterly, annually and with any change of condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #56) of 6 residents reviewed for ADLs. The facility failed to ensure Resident #56 had his fingernails cleaned and trimmed on 8/19/25. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Record review of Resident #56's Quarterly MDS assessment dated [DATE] reflected Resident #56 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident (a condition that occurs when blood flow to the brain is blocked. The blockage can lead to brain tissue death.), and elevated blood pressure. Resident #56's BIMS score of 14, indicated Resident #56' cognition was intact. The MDS assessment indicated Resident #56 required maximal assistance with bathing. Record review of Resident #56's Care Plan revised 07/02/25, reflected the following: Care area: Self-care deficit . Goal: [Resident #56] will accept assistance with area of dressing, grooming hygiene and bathing over the next 90 days . Interventions: . provide assistance with self-care as needed. In an observation and interview on 08/19/25 at 10:24 AM revealed Resident #56 was lying in his bed. The nails on both his hands were approximately 0. 3cm in length extending from the tip of his fingers. The nails were discolored tan and had brownish colored residue on the underside. Resident #56 stated he did not like his nails long and dirty and he did not tell staff because they were busy. In an interview on 08/19/25 at 2:08 PM, LVN I stated CNAs and nurses were responsible to clean and cut the residents' nails. LVN I stated she did not notice Resident #56's nails. She stated she would do it right then. She stated the risk would be infection control and injury. In an Interview on 08/20/25 at 3:42 PM, the DON stated nail care should be completed as needed and every time aides washed the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated he expected CNAs and nurses to offer to cut and clean nails if they were long and dirty. The DON stated the ADONs would do the routine rounds to monitor. The DON stated residents having long and dirty nails could be an infection control issue and skin break down if scratching. Record review of the facility's policy ADLs/Bathing revised February 2020, did not address the concern of fingernails care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 6 (Resident #66) reviewed for range of motion. The facility failed to implement interventions to prevent further decline of Resident #66's contracture to her left hand on 04/22/25. The facility failed to ensure physician orders were written for bilateral (left and right) palm guards for Resident #66 on admission on [DATE].This failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Findings included: Record review of Resident #66 Quarterly MDS assessment, dated 07/20/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (loss of cognition), anxiety (feelings of intense worry), and depression (feelings of sadness/loss of interest). Review of Section O- Special Treatments, Procedures, and Programs reflected there were no days of restorative programs performed for a splint or brace assistance. Record review of Resident #66's care plan, printed 08/19/25, reflected she was a fall risk related to contractures and paralysis dated onset of 10/07/24, and reviewed and continued 05/06/25. Interventions included anticipate resident's needs, check frequently, low bed, and therapy referral. Record review of Resident #66's Kardex, printed 08/19/25, reflected blank spaces for what the resident enjoyed doing, what made life meaningful to the resident, and contracture devices. Record review of Resident #66's current physician orders did not indicate an order for a palm hand guard. Record review of Resident #66's Kardex, printed 08/19/25, reflected a section for contracture devices was blank. Record review of Resident #66's admission record, dated 10/07/24, active order summary reflected an order for palm protector to left hand with an order start date of 10/21/21. Further review revealed page noting the Resident Representative's notes for Resident #66's care that included Fussy Behavior: If she shouts out, she is usually in pain or anxiety.Nighttime: Blue brace on left arm comes off and is replaced with smaller white brace. This is so she doesn't cut her hands with her fingernails. [NAME] brace can stay on right hand. (can come off for a few hours if it bothers her). Morning: Put blue brace back on. [NAME] brace can stay on right hand.Record review of Resident #66's treatment administration record for the month of August 2025 did not reflect a palm guard. Record review of the facility's contracture log reflected Resident #66 had a contracture to her left and right elbows flexion (bent) and her left and right hands and was on staff management. Resident #66 was last treated on 10/31/25 for physical and occupational therapy and was previously screened on 07/18/25. Resident #66 had bilateral (left and right) palm guards. Record review of Resident #66's therapy screening, dated 07/18/25, reflected she had contractures to both elbows in flexion (bent) and both hands. Further review reflected palm guards for [bilateral] hand contractures are managed by nursing staff, pt has had no functional changes and no skilled PT/OT/ST services are warranted at this time. with recommendations to continue current interventions. In an interview on 08/21/25 at 12:38 PM with the DON, he stated that Resident #66 had been assessed by the therapy department upon admission and most recently on 07/18/25 where the recommendation was to continue bilateral palm guards for her hand contractures. An interview and observation on 08/21/25 at 9:09 AM with CNA H revealed Resident #66 had on a palm guard to her left hand and none on her right hand. Observation of Resident #66's right and left hands with CNA H revealed her nails were trimmed with no jagged areas and the skin of her palms had no injuries. CNA H stated that the CNAs only had access to the Kardex and if there were resident preferences, CNAs were informed by nursing management or during change of shift and could find information in the Kardex. She stated she was aware that music helped Resident #66 calm down because other staff told her and she followed the signs the representative had placed in Resident #66's room. In an interview on 08/21/25 at 9:16 AM with CNA K, she stated she was the restorative aide for the facility. She stated Resident #66 was not currently on restorative services and had a hand brace due to a contracture.In an interview on 08/21/25 at 9:28 AM with the Director of Rehabilitation Services revealed Resident #66 had been assessed upon admission and quarterly. She stated Resident #66 was not currently on therapy services. She stated that she did not see any orders for a palm guard and the resident was on their contracture log which noted she had bilateral palm guards. She stated with the facility transferring to a new electronic health record, she was not sure if Resident #66 had an order for the bilateral palm guards. In an interview on 08/21/25 at 9:35 AM with LVN I, she stated Resident #66 was typically in bed and she had a contracture to one hand and wore a palm guard. She reviewed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #41) of two residents reviewed for incontinence care. The facility failed to ensure CNA P provided appropriate perineal care for Resident #41 after an incontinent episode when she failed to clean the resident's labia on 08/19/25. This failure could place residents at risk for the development and/or worsening of urinary tract infections. Record review of Resident #41's Quarterly MDS assessment dated [DATE] reflected Resident #41 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), and elevated blood pressure. Resident #41's BIMS score of 03, indicated Resident #41's cognition was severely impaired. The MDS assessment indicated Resident #41 was frequently incontinent of bowel and bladder. Record review of Resident #41's Care Plan reviewed 07/14/25, reflected the following: Problem: At risk for problems with elimination. Goal: Resident's elimination status will be maintained or improved over the next 90 days. Interventions: . provide incontinent care after each incontinent episode .In an observation on 08/19/25 at 2:56 PM revealed CNA P entered Resident #41's room to provide incontinence care. CNA C washed her hands and put on gloves and unfastened the brief to reveal the resident had been incontinent of urine. CNA P pushed the soiled brief down between the resident's legs, toward her buttocks and cleaned her peri area (the area of skin between the anus and the external genitalia) from the front to back but did not separate the labia and clean down the middle. CNA C rolled the resident onto her side revealing the resident had soaked through her brief. CNA C continued to provide incontinence care, wiping the resident's buttocks from back to front and reapplied a clean brief. She removed her gloves and washed her hands. An interview with CNA P on 08/19/25 at 3:02 PM revealed she failed to separate the resident's labia, and she wiped the resident's buttocks from back to front and by providing inappropriate incontinent care that could lead to an infection. She stated she had been in training and knew the importance of properly cleaning a resident. In an interview on 08/20/25 at 03:42 PM, the DON stated when providing incontinent care, staff were to clean the peri area including the labia for female residents, then moving toward the buttocks and always clean from the front to back. He stated by not providing accurate incontinent care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. He stated he would monitor by doing skills check on all CNAs periodically. Record review of the facility's policy titled, Perineal Care/Incontinent Care, dated April 2012, reflected, .For female patient/resident: Separate the labia and wash downward (down the center of labia), then downward on each side of the labia using a different per wipe with each stroke.Clean outer hip of buttocks going upwards towards back .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 4 residents (Resident #12) reviewed for quality of care. The facility failed to ensure LVN I followed physician ordered water flushes between each medication administration given via the G-Tube (a feeding tube surgically inserted through a small opening in the abdomen directly into the stomach, used to deliver nutrition, fluids, and medications when a person cannot ingest enough by mouth) for Resident #12 on 08/20/25. This failure could place residents at risk of nausea, shortness of breath and a decrease potential fluid overload. Record review of Resident #12's Comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male with an admission date 11/13/23. Diagnoses included traumatic brain dysfunction (brain dysfunction caused by an outside force), respiratory failure (lungs can't properly exchange gases) and gastroesophageal reflux (condition where stomach contents back up into the esophagus. Nutritional status revealed Resident #12 had a G-Tube.Record review of Resident #12's care plan reviewed on 06/09/25 reflected, Care Area: Presence of G-Tube . Goal: Resident will have no signs or symptoms of aspiration over the next 90 days . Interventions: Keep the head of the resident's bed at 30 degree and 45 degree, . Provide water flush as ordered, . Provide water flush at med pass per nursing policy. Record review of Resident #12's August 2025 Physician's order sheet report reflected, .G-Tube Flush 30 cc water before and after medications . Use 15 cc water flush in between each medication administered . with a start date of 07/25/25. An observation on 08/20/25 at 9:31 AM of G-Tube medication administration revealed LVN I prepared medication for Resident #12. LVN I placed 1 tablet of Baclofen 10 mg (muscle relaxant), 1 tablet of folic acid 1mg (B vitamin), 1 tablet of furosemide 40 mg (water pill), 1 tablet of vitamin C 500 mg, 1 tablet of vitamin B1, and 1 tablet of multivitamin with minerals in an individual cup and crushed each tablet. LVN I placed the 6 medication cups and a cup filled with approximately 8 ounces of water on a tray and entered the resident's room. LVN I poured approximately 10 cc of water into each medication cup and then retrieved a 60-cc piston syringe (a medical device with a hollow barrel and a plunger that creates a seal to draw in or expel fluids for medical uses) and placed the piston syringe into the G-tube connector and checked for residual. LVN I then flushed the G-tube with 30 cc of water and then administered the first medication by gravity and she did not flush the tube feeding with water; she administered the second medication by gravity and she did not flush the tube feeding with water; she administered the third medication by gravity and she did not flush the tube feeding with water; she administered the fourth medication by gravity and she did not flush with water; and she administered the fifth medication and then the sixth by gravity. She then flushed with 10 cc of water and then 30 cc of water. LVN I then reconnected the feeding tube and turned the pump back on. In an interview with LVN I on 08/20/25 at 9:56 PM she stated she was not required to flush the G-tube with water before and after each med pass. When LVN I looked at the medication administration record, she stated Oh it was supposed to be 10 ml of water after each medication. She stated she overlooked the orders. She stated she was required to review with physicians' orders prior to giving any medication and clarify if it was not clear. She stated not flushing with the prescribed amount of water could result in possible tube clogging. In an interview with the DON on 08/20/25 at 3:42 PM, he stated staff were to always to follow the doctors' orders on the amount of fluid to flush before and after medications. He stated failing to follow the orders could result in complications with the G-tube and discomfort to the resident. He stated not flushing with water could cause tube to clog. He stated all nurses were skills checked prior to G-tube medications administration and were expected to follow the physician ordered flushes. He stated any time a nurse questioned an order it was their responsibility to clarify the order. He stated they would be doing follow up monitoring to ensure staff were following proper procedures. Record review of the facility's policy, Irrigating a Feeding Tube, revised 04/22/2020, reflected, .Flush medication completely through the tube. Irrigate routinely before, between, and after final medication .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the attending physician documented in the resident's medical record that the identified drug irregularity had been reviewed and what, if any, action had been taken to address it. If there was to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record for 1 of 6 Residents (Resident #66) whose psychotropic medications were reviewed.Resident #66's attending physician failed to address the pharmacist's recommendation to consider a gradual dose reduction. Resident #66 had been receiving Citalopram (antidepressant) 20 mg and Risperidone once a day every day since October 2024 and Alprazolam .25 mg twice a day everyday since October 2024.This deficient practice could contribute to Residents receiving a higher medication dose than necessary and result in adverse side effects.The findings included: Record review of Resident #66 Quarterly MDS assessment, dated 07/20/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (loss of cognition), anxiety (feelings of intense worry), and depression (feelings of sadness/loss of interest). Review of Section N- Medications- N0415. High-Risk Drug Classes- reflected she was taking antipsychotic, antianxiety, and an antidepressant. N0450. Antipsychotic Medication Review reflected the resident received antipsychotic medications on a routine basis, a Gradual Dose Reduction (GDR) had not been attempted, and the physician had not documented the GDR as clinical contraindicated. Record review of Resident #66's care plan, printed 08/19/25, reflected she received anti-anxiety medication of Alprazolam .25 mg by mouth two times per day and interventions included administer medication as ordered, ask physician to review medication for possible dose reduction every 3 months, and monitor behaviors every shift and side effects, dated onset of 10/07/24 and reviewed and continued 05/06/25. She received an antidepressant medication of citalopram 20 mg tablet by mouth once per day and interventions of administer medications as ordered, monitor for worsening of depression, monitor duration-prior to discontinuation may need a gradual dose reduction or tapering to avoid a withdrawal syndrome, dated onset of 10/07/24 and reviewed and continued 05/06/25. She received the psychotropic medication risperidone .25 mg one tablet by mouth once per day and interventions included monitor for side effects and behavior every shift, and physician to review medication for possible dose reduction, dated onset of 10/07/24 and reviewed and continued 05/06/25.Record review of Resident #66's physician orders reflected an order for: Citalopram 20 mg, one tablet for by mouth, once daily for Major depressive disorder, recurrent severe without psychotic features with a start date of 07/29/25. Alprazolam 0. 25 mg tablet for Unspecified dementia, unspecified severity, without behavioral disturbance with a start date of 07/01/25 and discontinue date of 08/01/2025 and new start date of 08/01/25. Risperdal 0.5 mg tablet for Unspecified dementia, unspecified severity, without behavioral disturbance, administer 1/2 tablet 0.25 mg by mouth daily, with a start date of 07/18/25Record review of Resident #66's Medication Administration Record for the month of August 2025 (08/01/25-08/19/25) reflected she was monitored for behaviors regarding depression and side effects for antianxiety, antidepressant, and antipsychotic medications every shift. Record review of the Pharmacist's Medication Regimen Review Recommendations with documented outcomes between 06/01/25 and 06/18/25 reflected Resident has been taking the anxiolytic ALPRAZOLAM . 25 BID since 10/24 Please evaluate the current does and consider a dose reduction . With an outcome/response of declined without rationale. Review of Resident #66's progress notes from May 2025 to August 2025 did not reveal documentation which addressed the Consultant Pharmacist review, dated 05/11/25 or 06/18/25.In an interview on 08/21/25 at 12:38 PM with the DON, he stated he was responsible for reviewing the Medication Regimen Review (MRR) recommendations and ensuring the originals were signed by the physician with a response. He stated that he had recently starting working at the facility about 3 months ago, and had not noticed there was an issue with the MRR responses. He stated that usually the next step was a psychiatric assessment and then it was determined if a GDR should be attempted. He stated that Resident #66 had not received a GDR and was on the medications risperidone, alprazolam, and citalopram since she transferred from another facility in October of 2024. He stated that his expectation was that GDR trials were attempted unless it was contraindicated. He stated that GDRs were important because they could impact a resident's cognition and possibly could be on a medication that was not needed. He stated that moving forward, the facility would have interdisciplinary meetings with the Medical Director to review the residents on medications and GDR recommendations .In an interview on 08/21/25 at 1:24 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 (300 Hall Nurses Cart and 200 Hall Nurses Cart) of 4 medication carts reviewed for pharmacy services in that:The facility failed to ensure: 1- 300 Hall Nurses Cart did not have:o 1 insulin pen for Resident #64 without an open date on 08/19/25. o 1 insulin pen for Resident #58 without an open date on 8/19/25. o 1 insulin pen for Resident #7 without an open date on 08/19/25. o 1 insulin pen for Resident #51 without an open date on 08/19/25. 2- 200 Hall Nurses Cart did not have: o 1 insulin pen for Resident #44 without an open date on 08/19/25. These failures could affect residents resulting in diminished effectiveness and not receiving the therapeutic benefits of the medications.1- Record review and observation on 08/20/25 at 8:56 AM of the 300 Hall Nurses Cart, with RN A revealed: - The pen of insulin Lispro 100 unit/ml for Resident #64 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use. - The pen of insulin Novolog 100 unit/ml for Resident #58 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use.- The pen of insulin Lispro 100 unit/ml for Resident #7 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use.- The pen of insulin Lantus 100 unit/ml for Resident #51 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use Interview on 08/19/25 at 9:21 AM, RN A stated nurses were responsible to check the medication carts and the insulin pens for the open dates before giving insulin. He stated the nurse was supposed to label the pen with the open date when first opened. RN A stated the purpose of putting an open date was for expiration purposes because the insulin was only good for 28 days. He stated after 28 days the insulin would be ineffective. 2- Record review and observation on 08/19/25 at 9:27 AM of the 200 Hall Nurses Cart, with LVN I revealed: The pen of insulin Lantus 100 unit/ml for Resident #67 with no open date. Observation of the pen reflected it was used. And instruction on the pen reflected to discard after 28 days of use. Interview on 08/19/25 at 9:45 AM, LVN I stated nurses were responsible to check the medication carts and the insulin pens for the open dates before giving insulin. She stated the insulin was good for 28 days only after opened, after 28 days the insulin should be discarded because its effectiveness decreased. Interview on 08/20/25 at 3:42 PM, the DON stated the insulin flex pens and vials, once opened, needed to be dated because each insulin pen and vial had a specific day's shelf life and if not thrown out by that time the insulin could lose its effectiveness. The DON stated the pharmacy consultant checked the carts monthly and he stated he would do random checks of the medication carts for monitoring.Record review of the facility's policy titled Medication Storage, dated January 2024, reflected . Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in:1. The facility failed to ensure food items in the facility walk-in refrigerator, walk-in freezer and dry storage were dated or labeled.2. The facility failed to ensure food stored in the freezer were properly closed and sealed to prevent exposure to the air. 3. The facility failed to ensure during lunch service kitchen staff used proper hand hygiene while serving residents' trays on 8/19/25.4. The facility failed to take temperatures of all food being served during lunch service on 8/19/25.5. The facility failed to place serving spoons on a sanitized surface during lunch services on 8/19/25.These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination. Observation of the walk-in refrigerator and an interview with the Dietary Manager on 08/19/2025 at 8:47 am revealed: -a clear plastic sealed gallon-sized bag with 3, 8-ounce globs of thick white substance with no label of contents. The Dietary Manager stated it was cream cheese.-a clear plastic sealed gallon-sized bag with about a 1/4 full of small black 1-centimeter circular items without a label of contents. The Dietary Manager stated they were chocolate chips. She stated everything should have been labeled with what the contents were and should have had a date received and date opened. Observation of the walk-in freezer and an interview with the Dietary Manager on 8/19/25 at 8:57 am revealed: - a 20-lb opened box of beef patties, with about 65 patties left, in plastic bags opened to the air and not sealed. The Dietary Manager stated all food must be sealed and closed appropriately when in the freezer to prevent freezer burn. Observation of the dry goods storage area on 8/19/25 at 9:00 am revealed: -3, 5-lb bags of manufacture sealed plastic bags, filled with about 1 cm beige objects with no label of what the item was.-17 small plastic 2oz cups with lids and a brown liquid substance, not labeled with contents. An interview with the Dietician on 8/19/25 at 10:45 am revealed she had been helping the Dietary Manager because she was new to the position. She stated all items in refrigerator, freezer, and dry storage should be labeled with date received, date opened, and list the name of the item. She stated all food that was opened should be sealed. She stated the box of patties should be sealed and not opened to the air. She stated the 3 bags of beige items were rice crispy cereal and should be labeled when they removed them from their original box. She stated the risk to the residents of not properly labeling the items would be wrong items could be served to residents. The risk to residents of the frozen patties not being sealed appropriately would be freezer burned and poor-quality food. Observation of lunch service on 8/19/25 at 11:54am revealed the Dietary Manager was cooking gravy on the stove. She then poured the gravy in the warming tray. [NAME] M nor Dietary Manager temped the food before serving the gravy to the first resident. Observation of lunch service on 8/19/25 at 12:15 pm revealed two metal serving spoons on the metal counter in front of the warming food. [NAME] M's clothing was rubbing back and forth on the counter where the spoons were placed. [NAME] M grabbed one of the metal spoons on the counter and put it in the pureed meat and proceeded to serve a meal tray. Observation of lunch service on 8/19/25 at 12:40 pm revealed [NAME] M left the serving area with her gloves on and went to the freezer to grab frozen fries. She returned to the serving area with the same gloves and poured the fries from the bag into the fryer. She left the fries frying and took the frozen fries back to the freezer with the same gloves on. When she returned to the serving area, she had removed the gloves, but had not washed her hands. She then put a new set of gloves on and continued to serve food. She removed the fries from the fryer, poured them on to a plate, and handed the plate to the Dietary Manager who served them immediately and did not temp them. Observation of lunch service on 8/19/25 at 12:45 pm revealed the Dietary Manager asked [NAME] M for the oatmeal. [NAME] M got the cooked oatmeal that was already served and being held in a warmer and handed it to the Dietary Manager. The Dietary Manager removed the plastic covering over the oatmeal container, did not temp it, and served it on a tray. Interview with the Dietician on 8/19/25 12:50 pm revealed all food, to include gravy, fries, and oatmeal should have been temped. The Dietician stated the only item that should not need temping was bread. The risk to the resident of not temping all food was food borne illness and potentially undercooked food. The serving spoons were all sanitized and the counter should have been sanitized as well, however, since [NAME] M's clothing was touching the counter and the spoons were on it then there would be a risk for cross contamination. Regarding the observation of [NAME] M not washing hands between glove changes, she stated she corrected her once during the observation and would in-service her again. [NAME] M stated the risk to the residents of in-proper hand hygiene during food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 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 observation, interview and record review, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 (Resident #10, Resident #56, and Resident #61) of 5 residents reviewed for infection control. The facility failed to ensure MA N disinfected the blood pressure cuff in between blood pressure checks for Residents #10, Resident #56, and Resident #61. This failure could place residents at-risk of cross contamination which could result in infections or illness. 1.Record review of Resident #10's Quarterly MDS assessment, dated 07/25/25, reflected Resident #10 was a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included elevated blood pressure, multidrug-resistant organism (microorganisms that are resistant to at least one class of antimicrobial agents, including antibiotics, and wound infection). Resident #3 had a BIMS of 3 which indicated Resident #10's cognition was severely impaired. Record review of Resident #56's Quarterly MDS assessment dated [DATE] reflected Resident #56 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebrovascular accident (a condition that occurs when blood flow to the brain is blocked. The blockage can lead to brain tissue death.), and elevated blood pressure. Resident #56's BIMS score of 14, indicated Resident #56' cognition was intact. Record review of Resident #61's Quarterly MDS assessment, dated 06/16/25, reflected Resident #61 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included elevated blood pressure and type 2 diabetes mellitus. Resident #61's BIMS score of 11, indicated Resident #61's cognition was moderately impaired. Observation on 08/20/25 at 7:58 AM revealed MA N performing morning medication pass, during which time she checked the blood pressure on Resident #10. MA N did not sanitize the blood pressure cuff before and after using it on Resident #10 and continued to the next resident without sanitizing the blood pressure cuff. MA N then checked Resident #56's blood pressure. MA N did not sanitize the blood pressure cuff before using it on Resident #56. She continued to the next resident without sanitizing the blood pressure cuff. MA N then checked Resident #61's blood pressure. MA N did not sanitize the blood pressure cuff before using it on Resident #61. Interview on 08/20/25 at 8:40 AM, MA N stated reusable equipment, like blood pressure cuffs, should be sanitized before and after use on each resident in order to keep germs from spreading. She stated she forgot to sanitize the blood pressure cuff between residents' use.In an interview with the DON on 08/20/25 at 3/42 PM, he stated his expectation was for staff to sanitize the blood pressure cuff after each use. He stated to ensure staff were knowledgeable in the sanitation of the blood pressure cuff the facility would do skills competency checks and he stated he would make daily rounds and watched care and medication administration. Record review of the facility's policy titled Disinfecting and Sterilizing Resident Care Equipment, revised March 2025, reflected . Non-critical items are those that either do not ordinarily touch the residents or touch only intact skin. Such items include . blood pressure cuffs . it is imperative that these items are clean.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident bedside and toilet and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 3 of 23 residents (Resident#13, Resident#30, Resident #4) reviewed for resident call system. 1) The facility failed on 08/19/2025 to ensure the call light system was adequately equipped, the call light string was lying on the floor in the shared resident toilets located inside the resident rooms.2) The facility failed to ensure the call light device was within the reach of Resident #4 on 08/19/2025 when the resident was lying in bed in his room. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for activities of daily living.1) Record review of Resident #13's face sheet dated 08/21/2025 reflected she was a [AGE] year-old female with an original admission date of 07/18/2025. Record review of Resident #30's MDS dated [DATE] reflected he was an [AGE] year-old male with an admission date of 07/30/2025, BIMS sore of 09 indicated moderate cognitive impairment. His diagnoses included Chronic Obstructive Pulmonary Disease (breathing difficulty). Review revealed Resident #30 required partial to moderate assistance with ADLs. Observation on 08/19/2025 at 10:01 AM inside Resident #13's shared bathroom revealed the call light device string was lying on the floor. Interview with Resident #13 revealed she needed assistance with ADLs. Observation on 08/19/2025 at 01:12 PM inside Resident #30's shared bathroom revealed the call light device string was lying on the floor. An interview and observation on 08/19/2025 at 02:23 PM with the Maintenance Director at both Resident #13 and #30's bathroom, he looked at the call light string and stated the call light string was expected to stay above the floor, and he was responsible to repair and maintain the call light system. He stated the call light string lying on the floor increased the risk for call light device malfunction and he expected all the employees to notify him when they saw the string was lying on the floor. He stated all the employees regularly received in-service trainings on call light device and he would right away repair the call light device on both rooms. An interview on 08/19/2025 at 02:05 PM with LVN Q revealed it was the Maintenance Director's responsibility to repair, maintain and ensure the call light system was adequately equipped, and all the employees were responsible to let the Maintenance Director know that the call light string was lying on the floor. He stated the call light string was expected to stay above the floor and lying on the floor could affect the proper functioning of the device. He stated he and his employees regularly received in-services on call light devices. An interview on 08/19/2025 at 01:47 PM with RN R revealed it was the maintenance director's responsibility to repair, maintain and ensure the call light system was adequately equipped. RN R stated all the employees were responsible to let the maintenance director know that the call light string was lying on the floor. He stated the call light string was expected to stay above the floor and lying on the floor could affect the proper functioning of the device. He stated he and his employees regularly received in-services on call light devices. An interview on 08/19/2025 at 02:22 PM with CNA S revealed the Maintenance Director was responsible to repair, maintain and ensure the call light system was adequately equipped. CNA S stated all the employees were responsible to let the maintenance director know that the call light string was lying on the floor. He stated the call light string was expected to stay above the floor and lying on the floor could affect the proper functioning of the device. He stated he received an in-service on call lights within the past month. An interview on 08/19/2025 at 03:35 PM with DON revealed he expected the Maintenance Director to repair, maintain and ensure the call light system was adequately equipped and working properly. The DON stated all the employees were responsible to let the Maintenance Director know that the call light string was lying on the floor. He stated the call light string was expected to stay above the floor and lying on the floor could affect the proper functioning of the device. Th DON stated all the employees received an in-service on call lights within the past month. 2) Record review of Resident #4 MDS assessment, dated 07/18/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of cancer, dementia (loss of cognition), quadriplegia, and had moderately intact cognition. Record review of Resident #4 care plan, printed 08/19/25, reflected he had impaired physical mobility and was a fall risk due to quadriplegia, dated 06/24/25. Interventions included keep call light within reach and provide appropriate level of assistance to promote safety of the resident. Observation on 08/19/25 at 9:32 AM revealed CNA H exited Resident #4's room with his breakfast tray. In an observation and interview on 08/19/25 at 9:34 AM revealed Resident #4