STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455589	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565 Based on observation, interview, and record review, the facility failed to ensure that residents are free from abuse, neglect, misappropriation of resident property, and exploitation for one (Resident #1) of four residents reviewed for abuse. The facility failed to ensure Resident #1 was in a safe environment when LVN A recorded instances of pouring water onto her face, verbally taunting her, and striking her with her knee and sitting on her arm. An immediate jeopardy existed from 03/05/24 - 03/06/24. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the noncompliance prior to the beginning of the investigation. This failure could affect residents by placing them at risk for abuse that could cause diminished quality of life and increased psychosocial harm as well as physical harm. Findings included: Review of Resident #1's undated face sheet revealed she was an [AGE] year-old female admitted to the facility 07/18/19 with diagnoses including: depression, history of stroke (bleeding in the brain), dementia, and kidney disease requiring dialysis (removal of blood by a machine to clean toxins then replacing cleaned blood). Review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had moderate difficulty with her hearing. It further revealed she usually understood others and usually could be understood. The review also revealed Resident #1 had impaired vision that required corrective lenses. Resident #1's BIMS score was an 8, which correlated with moderately impaired cognition. Further review revealed that Resident #1 did not exhibit physical or verbal behavioral symptoms directed towards others nor behavioral symptoms not directed towards others. (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
	455589	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's latest care plan, dated 12/22/23, revealed Resident #1 was at risk for pressure related injury due to impaired mobility with intervention of administering medications as ordered and repositioning Resident #1 at least every 2 hours. Further review revealed Resident #1 was at risk for fluid deficit (dehydration) due to medications, dialysis and variable intake; the intervention for this concern was administer medication, encourage Resident #1 to drink fluids of choice, ensure fluids were within reach, and notify the nurse if Resident #1 refused to drink fluids. Further review revealed Resident #1 was at risk for discomfort/pain due to impaired mobility and recent hospitalization that led to dialysis; the intervention for Resident #1's potential discomfort/pain was anticipate her need for pain relief and respond immediately to any complaint of pain, evaluate the effectiveness of the pain intervention, and review for compliance. Further review revealed Resident #1 had a focus of being non-compliant with medication due to anxiety and interventions were to notify family and physician and notify supervisor. Review of the facility's self-report dated 03/06/24 revealed that LVN A used her cell phone camera to record herself verbally and physically abusing Resident #1. There was a total of 5 videos, with 2 being repeats, that were sent by LVN A to an undisclosed employee who then sent the videos to the corporate office of the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455589	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the videos, sent to Corporate 03/05/24, revealed LVN A poured water on Resident #1 who was lying in bed. LVN A was heard taunting Resident #1 when Resident #1 became upset about the water poured on her face. Resident #1 swung her left arm out at LVN A each time LVN A approached her bed. LVN A was seen kneeing Resident #1, who was lying on a scoop mattress, and telling Resident #1 that she was going to take these pills. Resident #1 was heard calling LVN A a Black Bitch as she swung her arm at LVN A when LVN A approached Resident #1's bed. LVN A was heard asking Resident #1 if she is gay and throughout the video LVN A was laughing and taunting Resident #1. The next video revealed LVN A continued to taunt Resident #1 and she sat on Resident #1 while commenting that she was sitting on her. LVN A was seen sitting on Resident #1's left hip area, getting up and motioning to sit again as Resident #1 swung her arm at LVN A. LVN A was then seen grabbing Resident #1's blanket and trying to take it from Resident #1 while laughing and telling Resident #1 she was going to take these pills. The next video showed LVN A tugging at Resident #1's blanket and telling her that she would take the blanket if Resident #1 did not take these pills. Resident #1 stated to LVN A that it was her blanket and called LVN A a bitch. Resident #1 struck out with her right arm toward LVN A and LVN A responded by pouring more water on Resident #1's face, which was turned away from LVN A. Resident #1 called LVN A a bitch and LVN A laughed and held the water above Resident #1's head while Resident #1 lifted her right arm above her face to protect from further water being poured. LVN A slowly pretends to pour the water on Resident #1 while Resident #1's arm was over her face for protection but then withdrew the cup of water and laughed, then slowly moved closer to again threaten to pour water on Resident #1's face, held the cup for a few seconds and then poured the water when Resident #1 had lowered her arm. LVN A stated she was going to pour the water and Resident #1 said go ahead and pour it on me. LVN A poured a small amount on Resident #1 who then stated pour it all on me as she wiped the water away. LVN A was laughing and facing the camera. In the next clip, LVN A was kneeing Resident #1 3 times with Resident #1 swinging her left arm toward LVN A after the first kneeing incident. LVN A then grabbed Resident #1's left arm by the wrist and told her to open her mouth while grabbing Resident #1's mouth, and then poking her several times in the breast/chest area while calling Resident #1's name. LVN A then sat down on Resident #1's left arm and part of her abdomen while holding a cup of medication to Resident #1's mouth and looking back at the camera. LVN A then pulled on Resident #1's chin and Resident #1 opened her mouth and LVN A tilted the cup, so the medication ended up in Resident #1's mouth. LVN A then laughed and said ha ha gotcha; LVN A then grabbed the phone/camera. In all 5 video clips Resident #1 was wearing the same clothing and LVN A was wearing the same clothing in all 5 clips. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455589	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/13/24 at 11:00 am with the ADM she stated that LVN A sent the videos to an unknown employee who then sent the videos to the corporate office on 03/05/24; the corporate office immediately contacted the ADM, around 03/05/24 at 3:30 pm, and ADM began suspension and termination paperwork. LVN A was not at work at the time, so ADM stated she contacted LVN A to come to the building to sign the suspension paperwork and that she would be terminated for abuse. Corporate office reported LVN A to the board of nursing and included the video files. ADM contacted the family, the police department , the ombudsman and reported to SA . In addition, she notified the MD. The ADM, with support staff from the Corporate Office, began in-servicing all employees on Abuse/Neglect/Exploitation, use of photography/social media, and HIPAA privacy laws. All in-servicing was started 03/05/24 and completed 03/06/24. In addition, skin sweeps of all residents were started 03/05/24 and completed 03/06/24. Resident #1 was assessed by nursing immediately and Social Work met with the resident and continued meeting with her through 03/13/24 (exit). Resident #1 was followed by Psychiatry, so a call for an immediate visit was made and a psychologist visited with Resident #1 on 03/11/24 (first available time). The psychologist had seen Resident #1 in the past and stated that she had not declined in her baseline from the last time he had seen her several months before and this visit. All residents were given safe resident surveys with no other issues identified. Staff were all given surveys related to LVN A and whether any staff had observed abusive behavior, but no witnessed or other issues were identified. An Ad Hoc QAPI was held with ADM, DON, and MD on 03/05/24. The dialysis clinic that Resident #1 visited 3 times per week were notified to be on alert. In addition, the facility notified every facility in a 60-mile radius that LVN A was terminated and not eligible for re-hire. ADM stated that the police detective informed the ADM that Resident #1's RP would have to press charges for LVN A to be charged with any criminal act. The ADM also stated that the facility would continue asking 5 alert and oriented residents about any abuse or neglect concerns and if the residents feel safe; these questions would be asked for the next 5 weeks (if no concerns are voiced in the future questioning). Record review of Resident #1's EHR assessments tab revealed a Weekly Skin Assessment was performed on 03/05/24 at 4:09 pm and revealed no bruising or skin tears, but noted bilateral non-pressure wounds to the heals which were not marked as new. Record review of the resident safe surveys revealed no other residents documented concerns about safety, nor did the residents feel abused and nor had they witnessed abuse at the facility. Record review of staff surveys revealed that no staff member documented witnessing abuse or neglect of any resident by LVN A nor by any other staff member. In addition, all staff were able to identify the ADM as the abuse coordinator to contact immediately should staff have any concerns about abuse or neglect. Record review of Resident #1's March 2024 Progress Notes revealed a progress note authored by the Social Worker (SW) on 03/05/24 at 6:02 pm and revealed the SW documented trying to interview Resident #1 about the abuse she endured from LVN A, but Resident #1 did not answer about abuse and asked for her breakfast. The SW documented that Resident #1 did not display signs of fear, distress or behavioral agitation. The next progress note authored by the SW on 03/06/24 at 12:24 revealed she contacted Resident #1's psychiatric provider who stated they would arrange for counseling services to contact the SW to setup an appointment. The SW authored a note on 03/06/24 at 5:01 pm that the counseling services contacted the SW, and a therapist would call the SW to discuss telehealth and in-person options. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455589	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview and observation on 03/13/24 at 3:00 pm with Resident #1 revealed her room was dark and she said to go away. Resident #1 appeared to be resting comfortably in bed; no concerns were visible. Police officer exited room moments before. During an interview with Police Detective on 03/13/24 at 3:10 pm he stated that he was gathering evidence still, as he had just attempted to interview Resident #1 but was unsuccessful. He further stated he still needed to interview Resident #1's RP and LVN A. He provided his contact information and stated he would provide an update and report when he was able. During an interview on 03/19/24 at 9:10 am with LVN A she stated that nobody liked Resident #1 because Resident #1 was physically abusive, used bad language and refused care. She stated that sometime in January of 2024, LVN A had a cup of water to give Resident #1 and Resident #1 swung her hand and caused a little bit of water to spill on Resident #1. She said Resident #1 would respond to requests from LVN A by calling her a bitch and Resident #1 said fuck you. She stated she was supposed to go to work on 03/06/24, and she picked up her paycheck on 03/05/24 and everything was fine but was contacted by the ADM on 03/05/24 around 5 or 6 pm and the ADM told her she was suspended pending an investigation. She said the ADM was not allowed to tell her the allegations. LVN A stated on 03/06/24 she was called and asked to come to the facility and was notified she would be terminated. She denied any further incidents of water being spilled on Resident #1, she denied raising her voice to Resident #1, putting her hands on Resident #1, or any other incidents that would be viewed as abusive. LVN A did state that she had documented when Resident #1 had aggressive behavior toward LVN A. Record review of Resident #1's January 2024 progress notes revealed that LVN A documented a behavior note on 01/30/24 at 7:22 am that further revealed that Resident #1 refused her medication and used foul language and told LVN A to leave her room. LVN A then offered Resident #1 her medication in the shower room and Resident #1 pulled LVN A's hair and knocked the medication cup out of LVN A's hand. LVN A then documented notifying Resident #1's RP of the encounter. Record review of Resident #1's February 2024 progress notes revealed that LVN A documented on 02/03/24 at 2:51 pm that she had contacted Resident #1's RP about a behavior incident earlier that morning (no description or note found specifying the incident) and that a new order for in-patient psychiatric services was placed and RP would be updated when new information was available. Further review revealed a progress note on 02/09/24 at 8:13 am authored by LVN A that stated LVN A called the Mental health and mental rehabilitation crisis hotline to report that Resident #1 was using explicit language and displaying inappropriate behavior (not described) towards LVN A and another staff; LVN A was waiting for a return phone call. Review of a note dated 02/09/24 at 11:22 am by LVN A that revealed the return call from the crisis hotline personnel recommended LVN A speak with RP and MD to obtain inpatient psychiatric services for Resident #1; LVN A spoke to the ADM who recommended LVN A speak to the SW. During an interview on 03/13/24 at 3:13 pm with LVN B, she stated the facility constantly trained on abuse and abuse prevention. She said, it starts your first day of work on the computer before you can work with residents. She stated at least once a month, but usually more, abuse was covered. LVN B stated the most recent abuse in-service was within the last week, she thought last Tuesday or Wednesday (03/05/24 or 03/06/24). She stated if she was concerned about abuse, she would have reported it to the abuse coordinator, the ADM and she felt the ADM would take it seriously. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455589	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/13/24 at 3:20 pm with LVN C, she stated that they were in-serviced at least every month on abuse and the most recent was within the last few days. If she suspected abuse, she would protect the resident and notify the abuse coordinator, the ADM. She stated the ADM was new, but seemed good, she said staff were told there was an incident of abuse and to watch Resident #1 for any signs of change from her baseline. LVN C said Resident #1 seemed to be having more good days this week than the last few weeks. During an interview on 03/13/24 at 3:26 pm with CNA D, she said she was trained on abuse at least every other month, but most recently last week. She said if she had witnessed abuse, she would have stopped it and notified the charge nurse immediately, then the DON, and the ADM who was the abuse coordinator. She gave the types of abuse and examples. During an interview on 03/13/24 at 3:37 pm with HK E she said abuse was mentioned in trainings and meetings at least 3 - 4 times a month, and the latest was within the last week. She stated Resident #1 had good and bad days, but Resident #1 had never been physical with her. She said sometimes Resident #1 would yell at her, but when HK E responded calmly to Resident #1 and told her what she was doing and kept talking to her that Resident #1 would calm down. She stated that usually staff stepped out and gave Resident #1 a moment to calm down and tried again later. Record review of in-services revealed all staff in-serviced on Abuse/neglect/exploitation, photography, social media usage, and HIPAA privacy laws which started on 03/05/24 and completed 03/06/24. Record review revealed an attendance sheet for an Ad Hoc QAPI meeting on 03/05/24 which included the ADM, the DON, and the MD. Record review of HR folder revealed termination paperwork that stated that LVN A was hired 11/17/23 and was suspended by the ADM on 03/05/24 with the ADM's stated intent to move straight to termination due to a substantiated allegation that LVN A abused a resident; the ADM also requested that LVN A be added to a list of people not to be rehired due to the abuse. Further review revealed a form titled Personnel Action Form and was marked Termination with LVN A's name and employee identification number. LVN A's final termination date was marked as 03/06/24, and her last day worked according to the form was 03/04/24. Further review of LVN A's HR folder revealed she was last in-serviced on Abuse/neglect/exploitation on the computer on 01/02/24. Further review revealed the facility documented all required background checks for LVN A, which included verification of her nursing license, criminal background check, check with the employee misconduct registry, and the state and federal office of the inspector general exclusion lists. Record review of March 2024 nursing schedule revealed LVN A was not scheduled after 03/05/24. Record review of facility's policy titled Abuse/Neglect dated 03/29/18 revealed abuse included . willful infliction of injury, intimidation, or punishment .verbal abuse included language that was disparaging or derogatory . Mental abuse included harassment, threats of punishment .physical abuse included . pinching, kicking, and hitting .