

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Fortress Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633</p> <p>Based on interview and record review, the facility failed to ensure residents were free from verbal abuse for 1 of 5 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to prevent Med Aide A, on 6/23/24, from verbally abusing Resident #1 when she used foul language and threatened to keep him up late.</p> <p>The noncompliance was identified on 6/23/24. The facility had corrected the noncompliance before the investigation began and was corrected 06/24/24.</p> <p>These failures could place resident at risk for emotional distress, fear, decreased quality of life and further abuse.</p> <p>Findings included:</p> <p>Review of the face sheet for Resident #1 reflected he was admitted to the facility on [DATE] with diagnoses of: Metabolic Encephalopathy, Pain, Stiffness of unspecified joints, Cerebral Infarction, Epilepsy, and Aphasia following Cerebral Infarction.</p> <p>Review of the Discharge MDS Assessment for Resident #1 dated 5/11/24 reflected Resident #1 was transferred to the hospital. His physical assessment reflected he could feed himself with set up and needed extensive assistance for all other ADLs. He was assessed as always incontinent of bladder and bowel.</p> <p>Review of the Care Plan for Resident #1 dated 5/14/24 reflected interventions were in place for: Seizure disorder, Fall risk r/t hemiplegia, metabolic encephalopathy/weakness, Heart Failure, Anemia, UTI (6/25/24), and a Stroke on 6/25/24.</p> <p>In an interview on 7/23/24 at 9:30 am the Administrator stated Resident #1 and his roommate Resident #5 confirmed the Med Aide A had threatened them verbally and stated she was punishing Resident #1 by keeping him up late. The Administrator stated the facility investigation confirmed verbal abuse and the Med Aide was terminated. The Administrator stated ongoing interviews had confirmed Resident #1 denied any harm from the incident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/23/24 at 10:00 am Resident #1 stated he felt fine and safe since the Med Aide was removed from the building. He stated she had demonstrated a bad attitude on different occasions. He stated he didn't think he needed to speak to a Psychologist or Councilor. Resident #1's speech was slow but he answered questions appropriately.</p> <p>Attempts to interview MED AIDE A were unsuccessful, three attempts were made to reach her by telephone on 7/23/24 at 9:30 am 11:18 am and 1:00 PM. No return call was received.</p> <p>Review of the facility investigation reflected the incident was reported on 6/24/24 and occurred on the evening of 6/23/24. Review of the incident report reflected Resident #1 was told by MA A I am punishing you for last night for being on the light. The Resident's room mate Resident #5 gave a statement to the administrator on 6/24/24 the Med Aide A left Resident #1 up in his chair until 10 PM on 6/23/24. On interview by the Administrator Resident #1 corroborated the statement. Resident #1 stated he had back pain . Assessment of Resident #1 showed no signs of physical injury.</p> <p>In a follow-up interview on 08/08/2024 at 11:18 AM Resident #1 up in w/c in room he stated he was ok and voiced no complaints about care or staff at the facility. When asked about MED AIDE A he stated 'who then was able to recall the incident he stated she did put him in bed at 10:00 pm because he was on his light last night and then she said if you do I will not put you to bed until 1:00 PM tomorrow. When asked if he felt abused and how the incident made him feel he stated, I feel like she was in a bad mood. Then stated no to being abused but yes to feeling threatened. He stated he felt safe at the facility and was happy with how the facility handled the situation. He stated did not have pain but did not want any pain medicine. He stated he usually went to bed at 6 or 7 pm. He stated MED AIDE A had taken care of him before and he stated he had not had any problems with her before.</p> <p>Review of facility investigation dated 07/01/2024 revealed the administrator and Social Worker interviewed Resident #1 individually as part of the facility investigation. Psych services conducted a brief interview and no adverse issues were reported.</p> <p>Review of Med Aide A Termination Statement dated 07/01/24 revealed Med Aide was suspended on 06/24/24 and terminated on 07/01/24.</p> <p>Review of a Statement from Resident #1 dated 6/24/24 reflected he had been kept up until 10 PM on 6/23/24 and the med Aide A threatened to keep him up until 1:00 am if he used the call light too much.</p> <p>Review of a Statement from Resident #5 dated 6/24/24 reflected he had overheard Med Aide A tell his roommate Resident #1 I am punishing you for last night for being on the light.</p> <p>Review of the Facility Policy on Abuse Neglect dated 3/29/2018 reflected the resident has a right to be free from abuse, neglect and misappropriation. Examples of verbal abuse in the policy include threats to harm or frighten a resident.</p> <p>Review of Abuse, Neglect and Exploitation Inservice dated 06/24/24 revealed all staff inserviced on abuse, negelct and exploitation.</p> <p>Review of Med Aide A's employee record reflected she was hired 4/15/2022 back ground check completed, her last abuse prevention training was done 5/29/24 no disciplinary actions.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 08/08/2024 at 9:35 AM revealed staff interacting at the facility respectfully with residents.</p> <p>In an interview on 08/08/2024 at 9:55 AM Resident #10 stated he thought the staff were competent and felt safe at the facility. He denied any abuse.</p> <p>In an interview on 08/08/2024 at 9:57 AM Resident #11 stated she felt safe and had no concerns for abuse or neglect.</p> <p>In an interview on 08/08/2024 at 11:00 AM RN G stated she was educated regarding the facility abuse and neglect policy and would notify their abuse coordinator, the administrator. If she did not feel the situation was addressed by the abuse coordinator she would notify HHSC.</p> <p>Review of Satisfaction Rounds by the Social Worker dated 06/27/2024 revealed the social worker completed satisfaction rounds with all residents with no additional concerns revealed.</p> <p>Review of Resident #1's Care plan dated 06/25/2024 revealed Resident #1's care plan was updated for recent trauma related to abuse for incident with MED AIDE A.</p>