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	04/16/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observations, interviews, and record review, the facility failed to ensure that residents who needed respiratory care was provided such care, consistent with professional standards of practice, for 3 of 4 residents (Resident #1, Residents #2, and Resident # 3) reviewed for the use of oxygen cannula and nebulizer. The facility failed to ensure: -Resident #1 and Resident #2's nebulizer mask and tubing were in a bag. - Resident #3's oxygen cannula was in a bag This failure could place residents at risk for respiratory infections. The findings included: 1. Record review of Resident #1's face sheet on 04/16/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were acute respiratory failure with hypoxia (low oxygen level), Dementia, Anxiety, Hypertension, Type 2 diabetes mellitus and Iron deficiency. Record review on 04/16/25 of Resident #1's initial MDS assessment, dated 02/15/25 revealed a BIMS score of 12 indicating his cognition was moderately impaired. Record review on 04/16/25 of Resident #1's care plan dated 04/08/25 reflected he had COPD (Difficulty to Breath), and the relevant intervention was administering bronchodilators (agents that dilates airways) and oxygen therapy as ordered by the physician. Record review on 04/16/25 of Resident #1's physician's order reflected: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML. 3 milliliter inhales orally every 4 hours as needed for SOB or Wheezing via nebulizer. 2. Record review of Resident #2's face sheet on 04/16/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were COPD (Difficulty to Breath), Acute respiratory failure with hypoxia, Anxiety disorder, Heart failure, Presence of cardiac pacemaker and Hypertension. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 04/16/25 of Resident #2's quarterly MDS assessment, dated 04/07/25 revealed a BIMS score of 15 indicating his cognition was intact. Record review on 04/16/25 of Resident #2's care plan dated 04/08/25 reflected he had COPD, and the relevant intervention was administering bronchodilators and oxygen therapy as ordered by the physician . Record review on 04/16/25 of Resident #2's physician's order reflected: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours as needed for Wheezing/SOB. 3. Record review of Resident #3's face sheet on 04/16/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were Hypertension, Type 2 diabetes mellitus, Chronic obstructive pulmonary disease, Heart failure, and End stage renal disease. Record review on 10/16/24 of Resident #3's quarterly MDS assessment, dated 03/27/25 revealed a BIMS score of 15 indicating her cognition was intact. Record review on 04/16/25 of Resident #3's care plan dated 03/28/24 revealed there were no care plan for oxygen therapy. Record review on 04/16/25 of Resident #3's physician's order on 04/26/25 reflected:. 1.Check O2 sat Q shift and PRN every shift. 2.Oxygen 2-5L PRN for comfort/keep oxygen saturation >92% as needed for SaO2 < 92%. Record review of Resident #3's April 2025 MAR on 04/16/25 at 11:30am revealed the O2 level was checked on every day in April,2025, every shift. The last check was on 04/16/25 in the day shift. During an observation and interview on 04/16/25 at 10:50 a.m., Resident #1 was lying in his bed . He was using oxygen through a cannula. There was a nebulizer on the bed side table. The mask and tubing of the nebulizers were exposed to the environment as they were not stored in a protective bag. There was a male urinal bottle sitting next to the exposed nebulizer mask of Resident #1. He stated the staff administer medication via nebulizer occasionally. He stated he could not remember when had used it lately. Resident #1 stated he used the urinal bottle regularly as he was not able to get out of bed for toileting. He stated he used the bottle about 30 minutes ago. During an observation and interview on 04/16/25 at 11:10 a.m., Resident #2 was lying in bed in his room. There was a nebulizer on his bedside table that was not secured in a protective bag. Resident #2 stated he had breathing difficulties and used inhalers and oxygen therapy regularly. During an observation and interview on 04/16/25 at 11:25 a.m., Resident #3 was in her room lying in her bed. Her oxygen cannula and tubing were laying on the floor. She stated she was not able to get up from bed and the staff assisted her to administer oxygen via a canula occasionally on request. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with DON on 04/16/25 at 11:35 a.m., it was revealed the nebulizers and oxygen canula were at the same places as the previous observations, exposed to the open air . The DON who observed the masks and canula stated they were supposed to be stored in protective bags whenever not in use. The DON stated all staff were supposed to be compliant with the facility policy for using the oxygen cannula and nebulizers. She stated she noted down this deficiency in infection control practices among the staff and stated they needed more in services and training on oxygen and nebulizer therapies, sooner than later. She stated bagging the masks and cannulas while not in use was necessary to minimize the risk of spreading respiratory diseases among the residents. Record review of the facility's policy, titled Protocol for Oxygen administration revised on 03/21/2023 reflected: change the tubing (including any nasal prongs or mask) that is in use on one patient when it malfunctions or becomes visibly contaminated. Record review of facility's policy titled Infection Control policy and procedure manual 2019 updated in March, 2024 reflected: The facility will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.