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 10/24/2024
NAME OF PROVIDER OR SUPPLIER: Fortress Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1105 Rock Prairie Rd College Station, TX 77845	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observations, interviews, and record review the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs for 2 (Resident # 24, and Resident #45) out of 8 residents reviewed for call lights. The facility failed to ensure Resident # 24 and Resident #45's call light was within reach. This failure could affect all residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: 1. Record review of Resident #24's Face Sheet, dated 10/23/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of unspecified lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance , mood disturbance and anxiety (a group of symptoms that affect the brain, such as memory loss, personality changes, and difficulty thinking can be mild or mixed without any behaviors), and personal history of traumatic brain injury (an injury to the brain caused by an external force, such as a blow to the head or an object penetrating the skull). Record review of Resident #24's Quarterly MDS Assessment, dated 09/23/2024, reflected Resident #24 had a BIMS score of a 3 indicating his cognition was severely impaired. Resident #24 was assessed to be dependent on staff for the following ADLs: personal hygiene, dressing, showers, toileting hygiene, chair to bed, and bed to chair transfers. Record review of Resident #24's Comprehensive Care Plan revised on 07/21/2024 and target date of 10/22/2024 reflected Resident #24 was at risk for falls related to impaired mobility and dementia. Intervention: be sure Resident #24's call light was within reach and encourage the resident to use it for assistance as needed. Resident #24 had an ADL self-care deficit. Intervention: Encourage Resident #24 to use bell to call for assistance. Observation and interview on 10/22/2024 at 9:15 AM, Resident #24 was lying in bed. His call light was located under his bed. (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: 455589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24 stated no when asked if he knew where his call light was located. He stated yes when asked if he used the call light. Resident #24 did not respond to any further questions such as: is his call light usually within reach and how would he call for help if his call light was on the floor. 2. Record review of Resident # 45's face sheet dated 10/23/2024 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbance (a group of symptoms that affect the brain, such as memory loss, personality changes, and difficulty thinking can be mild or mixed with behavior problems), unspecified mood (affective) disorder (a diagnostic category for people who have mood disorder symptoms that do not meet the criteria for another mood disorder diagnosis), and Alzheimer's disease (a progressive, irreversible brain disorder that destroys memory and thinking skills, and eventually the ability to perform daily tasks). Record review of Resident #45's Quarterly MDS Assessment, dated 09/07/2024, reflected Resident #45 had a BIMS score of 0 indicating her cognition was severely impaired. Resident #45 was assessed to be dependent on staff for the following ADLs: personal hygiene, dressing, showers, toileting hygiene, chair to bed, and bed to chair transfers. Record review of Resident # 45's care plan, dated 09/15/2024, reflected the resident was at risk for falls. Intervention: Ensure the resident's call light was within reach and encourage resident to use it for assistance as needed. Resident #45 had an ADL Self Care Performance Deficit. Intervention: Encourage Resident #45 to use bell to call for assistance. Observation and interview on 10/22/2024 at 9:28 AM, Resident #45 was lying in bed. She had a soft pad call device and it was hanging over the side of her bed. Resident #45 was not capable of reaching the soft pad call device. In an attempted interview on 10/22/2024 at 9:30 AM, Resident #45 was not interview able In an interview on 10/22/2024 at 9:32 AM, CNA C revealed Resident #45 required a soft pad call device related to Resident #45 was not physically or mentally capable of using a call light button. CNA C stated it was easier to pat the soft pad call device. She stated the call light device was hanging over the bed and Resident #45 was not able to reach the call device. CNA C stated if Resident #45 needed assistance she would not be able to yell for help or do anything to alert staff she needed assistance because she spoke with a very soft voice and it would be difficult to hear Resident #45. CNA C stated she had been in-serviced on call lights; however, she did not recall the time or date of the in-service. She stated all call lights needed to be on the bed where the Resident was able to find and use the call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/22/24 at 10:00 AM, CNA B stated the residents needed their call lights within reach. She stated if a resident needed assistance with any type of ADL care such as: toileting, transferring, dressing, etc. the Residents needs would not be met if they were unable to call for help. CNA B stated most residents have a regular call light except Resident # 45 who has a soft pad call device. She stated she knew Resident #45 was confused sometimes and it was easier for her to find the soft pad call device. CNA B stated Resident # 45 had a soft voice and it would be difficult to hear her talk loud when she was in her room. She stated it would be impossible for Resident #24 to obtain his call light from under Resident #24's bed. CNA B stated Resident #24 would have difficulty receiving any type of assistance he may need if he did not have his call light in reach. CNA B stated she had been in serviced on call lights. She stated all call lights were expected to be in reach of all residents at all times. She stated the nursing staff or any staff can check call lights. In an interview on 10/24/2024 at 10:15 AM, RN A stated if a resident's call light was not within reach of the resident there was a possibility a resident may fall and break a hip or hit their head on the floor attempting to reach the call light. LVN A stated it would be difficult to hear Resident # 24 and Resident #45 if staff were not near their rooms. She stated it was the responsibility of all staff in the facility to check call lights when they entered a resident room to ensure the call light was attached where the residents had easy access to use the call light. RN A stated she had been in-serviced on call lights and placing the call light within reach of the resident when they were in their room. RN A did not recall the last time he received the in-service. In an interview on 10/24/2024 at 10:30 AM, the Administrator stated the facility did not have a policy on call lights. The administrator did not respond to the following question: What was his expectation of the call lights being within reach of a resident. Was there a possibility if the call light were not in reach and a resident may need emergency nursing assistance and would not be able to call out for help. In an interview on 10/24/2024 at 10:43 AM, the Corporate Regional Director stated a call light under the bed and over the bed was not within reach of a resident. She stated there was a possibility a resident may attempt to assist self out of bed to locate the call light. The Corporate Regional Director stated any staff can check call lights to ensure the resident was capable or reaching the call light. The Corporate Regional Director stated the facility did not have a policy on call lights but her expectations were the call lights be within reach of the residents at all times. In an interview on 10/24/2024 at 11:25 AM, the DON stated it was all the staff's responsibility when they entered a resident room to ensure the call light was within reach of the resident. She stated if the call light were not within reach, it would be difficult for a resident to obtain the help they may need in a timely manner. She stated some residents were able to yell for help and some residents would not be able to yell loud enough. She stated a resident had a potential to fall if the resident attempted to reach for their call light. The DON stated a resident may need medical emergency and would not be able to use the call light for nursing assistance. The DON stated it was safe practice for all staff to ensure call lights were within reach of all residents. She stated an in-service had been given to all staff on call light placement. She stated she did not recall the date when the in-service was given to the staff. Record request on 10/24/2024 at 10:30 AM, of the call light facility's policy from the Administrator. He stated the facility did not have a call light policy.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44174 Based on record review and interviews, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being for 1 (Resident #40) of 25 residents reviewed for care plans, in that: 1. The facility failed to ensure Resident #40's comprehensive care plan addressed a discharge plan. This failure could place the residents at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #40's Face sheet, 10/22/2024, reflected she was a [AGE] year-old woman, who was admitted to facility on 9/28/24 with a diagnoses of clostridioides difficile (C.Diff [contagious bacteria]) acute osteomyelitis (serious bone infection), right ankle and foot, cellulitis (bacterial infection) right toe, type II diabetes (insulin resistance), major depressive disorder and generalized anxiety. Record review of Resident #40's MDS 10/22/2024, indicated she had a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognitive function. In an observation and interview with Resident #40 on 10/22/2024 at 2:10 PM, resident was observed to be clean and appropriately groomed. She reported that she was doing okay and felt safe at the facility. The resident stated she is on antibiotics due to a bone infection. She stated she is scheduled to return home on November 2, 2024, and had no concerns. Records review on of Resident #40's comprehensive care plan dated 9/28/2024, reflected the resident's diagnosis with a focus on interventions that were actively being completed to support residents' health. Record review on 10/24/2024 at 9:00 AM, Resident #40's comprehensive care plan dated 9/28/2024 and later revised 10/14/2024, revealed there was no discharge plan. Record review of the facility's Discharge Planning Process Policy and Comprehensive Care Planning Policy revealed facility policy stated a comprehensive care plan will be developed within 7 days after completion of the comprehensive assessment. In an interview on 10/24/2024 at 2:10 PM, Minimum Data Set Nurse (MDS) stated a resident's discharge should be documented in their care plan. MDS stated there could be some potential negative effects when discharge information is missing, leading to possible negative outcomes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/24/2024 at 2:15 PM, Social Worker (SW) stated the discharge plan has not been part of the care plan in the past but believed it should be included. SW was questioned on how staff would be aware of a resident's discharge plan if a discharge was to occur, she stated she hoped they would review the progress notes, though she was unsure if they would. SW stated she has not been trained on the facility's policy and procedures for discharge. In an interview on 10/24/2024 at 2:23 PM, Director of Nursing (DON) stated, the discharge plan is created at the new admission. When asked if the discharge plan was part of the care plan, she stated it probably should be included. She stated the SW initiates the assessment while the team is responsible for the care plan. She stated the admission meeting usually have the MDS, SW, Dietary, Rehab Director, and Activity Coordinator present. DON stated the interventions would be documented on a care plan along with the discharge information. DON stated there is a potential for a bad outcome with no information documented but they usually have a care plan meeting before discharge.

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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** 40884 Based on observations, interviews, and record review, the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for three of eight residents (Resident #17, Resident #24, and Resident #35) reviewed quality of life. 1. The facility failed to ensure Resident #17 and Resident #24 nails were cleaned. 2. The facility failed to ensure Resident #35 nails were trimmed and did not have any rough edges. These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings include: 1. Record review of Resident # 17's Face Sheet dated, 10/23/2024, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), neuroleptic induced parkinsonism (slowed movements, difficulty with fine motor tasks, problems with balance, walking, and resting tremor), tremor unspecified (a neurological condition that causes involuntary shaking or trembling in one or more parts of the body), and cognitive communication deficit (difficulty with communication that is caused by an impairment such as memory, attention, or problem-solving). Record review of Resident #17's Annual MDS Assessment, dated 08/20/2024, reflected the resident had a BIMS score of 5 indicating his cognition was severely impaired. Resident #17 required supervision or touching assistance with personal hygiene, lower body dressing, showers, transfers, and toileting hygiene. Record review of Resident #17's Comprehensive Care Plan, revised on 09/10/2024 reflected Resident #17 had an ADL self-care performance deficit. Interventions: Bathing- Check nail length, trim and clean on bath day and as necessary. Report any changes to the nurse. Resident #17 had an alteration in neuroleptic induced Parkinson. Intervention: cueing, reorientation as needed. Monitor/ document/ report to MD as needed signs and symptoms of tremors, rigidity, dizziness changes in level of consciousness, and slurred speech. Observation on 10/22/2024 at 9:37 AM, resident #17 was propelling self in his wheelchair from his room into the hall. Resident #17 had blackish / brownish substance underneath all of his nails on his right hand. In an interview on 10/22/2024 at 9:38 AM, Resident #17 stated he thinks he knows what it is underneath his nails but he was not going to tell anyone. Resident #17 stated he did request for his nails to be cleaned yesterday and the girl that works here told him someone would clean them when he got a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's Face Sheet, dated 10/23/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses unspecified lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance , mood disturbance and anxiety (a group of symptoms that affect the brain, such as memory loss, personality changes, and difficulty thinking can be mild or mixed without any behaviors), and personal history of traumatic brain injury (an injury to the brain caused by an external force, such as a blow to the head or an object penetrating the skull). Record review of Resident #24's Quarterly MDS Assessment, dated 09/23/2024, reflected Resident #24 had a BIMS score of a 3 indicating his cognition was severely impaired. Resident #24 was assessed to be dependent on staff for the following ADLs: personal hygiene, dressing, showers, toileting hygiene, chair to bed, and bed to chair transfers. Record review of Resident #24's Comprehensive Care Plan revised on 07/21/2024 and target date of 10/22/2024 reflected Resident #24 had an ADL self-care deficit. Intervention: Resident #24 required assistance with bathing: check nail length, trim, and clean on bath day and as necessary. Report any changes to the nurse. If diabetic, the nurse will provide toenail care. Resident #24 was dependent on staff for activities, cognitive stimulation, social interaction related to dementia. Interventions: Resident #24 needed assistance with ADLs as required during the activity. Observation on 10/22/2024 at 9:40 AM, Resident #24 was lying in bed. Resident #24 had blackish/brownish hard substance underneath his forefinger and middle fingernails. In an interview on 10/22/2024 at 9:42 AM, Resident #24 was asked if he reported to anyone about his nails having a blackish/brownish substance underneath two of his nails on his right hand. He stated, yes but don't know who. Resident #24 did not respond to any other questions such as: when he reported his nails being dirty and how long they had been dirty. 2. Record review of Resident #35's Face Sheet, dated 10/23/2024, reflected a [AGE] year-old female was admitted on [DATE] and readmitted on [DATE] with a diagnosis of multiple sclerosis (a chronic disease that damages the central nervous system, including the brain and spinal cord- this damage can slow or block messages between the brain and body, leading to a range of symptoms such as muscle weakness, difficulty with coordination and balance, numbness, thinking and memory problems, etc.), muscle wasting and atrophy (muscle wasting or thinning of your muscle mass). Record review of Resident #35's Quarterly MDS Assessment, dated 10/04/2024, reflected the resident had a BIMS score of 8 indicated her cognition status was moderately impaired. Resident # 35 was dependent on staff for personal hygiene, dressing, showers, toileting hygiene, oral hygiene, and transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 35's Comprehensive Care Plan, revised on 10/17/2024, reflected Resident #35 had an ADL Self Care Performance Deficit. Resident #35 will maintain or improve current level of function in personal hygiene. Resident #35 required assistance with bathing. Resident #35 had multiple sclerosis. Intervention: Pain management as needed. Give medications as ordered. Resident #35 was at risk for falls related to multiple sclerosis and muscle wasting and atrophy. Interventions: anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Resident #35 needed activities that minimize the potential for falls while providing diversion and distraction. Record review of Resident #35's Physician Orders and she did not have a diagnosis of diabetes or being administered any type of diabetic medication. Observation on 10/22/2024 at 10:13 AM, Resident #35 was in her room lying in bed. Resident #35 had approximately 2-inch nails on both hands. Resident #35 had rough edges around her ring and middle fingernails on her right hand. There were no scratch marks on her left or right hands or arms. In an interview on 10/22/2024 at 10:16 AM, Resident #35 stated she asked someone few days ago if they would trim her nails and file them. She stated she explained two of her nails were broken and she was scratching herself and leaving scratch marks on her left arm first of October (2024). She stated she bent one of her nails back and it broke. Resident #35 stated this is when the nails became rough and had a point on the corner of two of her nails(she pointed to the ring and middle finger of her right hand). She stated staff she talked to about her nails stated the aides was not allowed to cut or trim nails that was the nurses job. She stated she was not a diabetic. Resident #35 did not recall the CNA's name or the day this conversation occurred in Resident #35's room. In an interview on 10/22/2024 at 9:32 AM, CNA C stated the CNAs was responsible for cleaning, trimming, and filing all residents' nails except for the residents with diagnosis of diabetes. She stated the nurses was responsible for all residents' nails with diagnosis of diabetes. CNA C stated residents nails were usually cleaned on their shower days and as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill such as vomiting and diarrhea. CNA C stated there were also a possibility a resident may become severely dehydrated and may need to be transferred to emergency room to determine what type of bacteria was underneath the residents' fingernails. CNA C stated a resident may scratch their face or their arm. She stated a resident may cause a skin tear on their skin if the nail was not filed. CNA C stated she had been in-serviced on cleaning, filing and trimming residents' nails but she did not recall the date. CNA C stated she was not aware of Resident #17, Resident #24 or Resident #35 refusing nail care. She stated Resident #24 sometimes refused to be shaved. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/22/2024 at 10:00 AM, CNA B stated the nurses completed all diabetic fingernails, and the CNAs were responsible for all other residents' nails. She stated the CNAs were responsible to complete nail care such as trimming, filing, and cleaning the nails during showers. CNA B stated if a resident's nails needed to be cleaned, trimmed, or filed and it was not their shower day, the staff were expected to do any type of nail care as needed. CNA B stated if a resident had blackish substance underneath their nails, it was probably some type of bacteria. CNA B stated if a resident swallowed bacteria it was a potential the resident may develop major stomach problems such as nausea and/or diarrhea. CNA B stated if a resident became severely ill the resident may need to be transferred to emergency room for more care. CNA B stated if a resident had rough edges around their nails it was a possibility the resident may scratch themselves and develop a skin tear or scratch another resident. She stated Resident # 17, Resident #24 and Resident #35 did not refuse nail care. CNA B stated Resident #24 would refuse to be shaved. She stated she had been in-service on nail care but did not remember the date of the in-service. She stated it had been approximately 6 months to a year. In an interview on 10/24/2024 at 9:45 AM, RN A stated the CNAs was responsible for cleaning, trimming, and filing all residents' nails except for the residents with diagnosis of diabetes. RN A stated the nurses was responsible for all residents' nails with diagnosis of diabetes. RN A stated residents' nails were usually cleaned, filed, and trimmed on their shower days. She stated if a resident had a hang nail or their nails were dirty, nail care was expected to be completed as needed. RN A stated if a resident had nails that were rough around the edges, there was a possibility a resident may scratch themselves and develop a skin tear. RN A stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill with stomach issues such as vomiting. RN A stated there was a potential for a resident to develop or a throat infection. RN A stated she had been in-serviced on cleaning, filing and trimming residents' nails. RN A stated she did not remember the date of the in-service. She stated she was not aware of Resident #24, Resident #17 or Resident #35 refusing nail care. She stated sometimes Resident #24 would refuse clothes to be changed and to be shaved. In an interview on 10/24/2024 at 10:30 AM, the Administrator stated he would need to refer to the facilities policy on nail care when he was asked of his expectations of cleaning and trimming residents nails. In an interview on 1024/2024 at 10:43 AM, the Corporate Regional Director stated the nurses was expected to perform nail care including trimming and cleaning on the residents with diagnosis of diabetes (a disease that occurs when your blood glucose, also called blood sugar, was too high). The Corporate Regional Director stated the CNAs was expected to trim and clean all other residents' nails during showers and as needed. She stated if there was a blackish/ brownish substance underneath a resident's nails there was a possibility it may be bacteria. She stated if a resident ingested some bacteria there was a possibility a resident may have stomach issues, however, it was according to what type of bacteria was underneath the residents fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/24/2024 at 8:45 AM, Director of Nurses stated if a resident ingested blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria. She stated a resident may become physically with infection of their stomach. She stated there was a possibility a resident may develop vomiting or diarrhea. She stated all residents was expected to receive nail care during showers and as needed. Director of Nurses stated the CNAs completed nail care on all residents except for the residents with diagnosis of diabetes (a disease when your blood sugar was too high). She stated it was the nurse's supervisor responsibility to monitor residents nail care. The facility Policy on Nail Care, dated 2003, reflected Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions and the resident will be free from infection.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview and record review, the facility failed, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for all residents in the facility. 1. The facility failed to provide activities as scheduled on October 5th- October 6th, October 12th- October 13th , and October 19th to October 20th. These failures placed residents at risk of boredom, depression, increased behaviors, and diminished quality of life. Findings include: Record review of the resident participation record for October 2024 no activities did not occur on the weekends. Record review of the Activity Calendar the times for activities on the weekend was not documented on the activity calendar. The activity participation records for the month of October weekend activities were not provided for the residents on the following dates: a. 5th: Activity of Choice Outside Social Hydration Station b. 6th: Football Social Word Puzzles Dominoes c. 12th: Good News Social College Football Social Crossword Puzzles d. 13th: Football Social Morning News (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activity of Choice e. 19th Activity of Choice Name that [NAME] College Football Social f. 20th Football Social Music Memory Word Find Pages In a confidential Resident Group Meeting on 10/23/2024 at 10:00 AM, there were nine residents present for the meeting. All nine residents stated there was not any weekend activities during the month of October 2024. The residents in the group stated they did not understand the weekend activities on the activity calendar. All residents discussed some of them did not enjoy football, puzzles, or dominoes. The residents in the group were voiced their concerns about most of the residents in the facility was not able to come out of their room and was not able to do puzzles or dominoes. The group also stated there were not any times on the calendar and they did not know what time the activity began on weekends. One person stated it has football social in the morning and football does not come on television until the afternoons. The group stated some of the residents' watches football does not prefer to watch the same teams. The group was asked what was name that [NAME] and everyone in the group stated they had never heard of [NAME]. The group stated during the week there is activities and they liked the Activity Director, however, she could not be at the facility seven days a week. The group stated someone needed to work on weekends to only do activities. Five of the seven residents in the meeting stated the CNAs and nurses did not have time to do activities on the weekends they were busy giving care and we do not want them to do activities it would decrease time giving care. One resident stated she became sad and lonely on the weekends because there was not anything to do. Five of the seven residents in attendance stated they became bored. One of the seven residents stated he felt this was when there were more behaviors from the residents on the weekends. The residents in the group stated activities were discussed in group but it was for during the week and not on weekends. In an interview on 10/22/2024 at 9:30 AM, CNA C stated she did work sometimes on the weekends. She stated no one had discussed doing activities with the residents on the weekends with her. CNA C stated the nurses and the CNAs did not have time on the weekends to do activities in the dining room with the residents. She stated they were very busy giving care to the residents. CNA C stated if the staff did activities the residents care would decline. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/24/2024 at 10:15 AM, RN A stated the staff was very busy on the weekends providing ADL care to the residents. She stated she had not observed any activities occurring on the weekends especially during the month of October 2024. RN A stated it would be very helpful if volunteers came in on weekends and did activities with the residents or hire a part time assistant to work weekends. She stated there was an activity assistant and she was no longer there as of few weeks ago. RN A stated there were activities during the week but not on weekends. She stated if residents did not receive activities there was a possibility a resident may become depressed, bored, have a decline in their cognition and/ or isolate themselves in their rooms. In an interview on 10/24/2024 at 10:30 AM, the Administrator stated his expectations of the activity department was to follow the facility policies and CMS regulations. When asked if there was a possibility a resident may become bored or sad if they did not have activities on the weekends, the Administrator did not respond to the question. When asked about the participation records and if he expected the activities be documented when an activity occurred in the facility or outside the facility, the Administrator did not respond. The Administrator did not respond when asked who was responsible to ensure the Activity Director was providing activities for the residents on weekends. In an interview on 10/24/2024 at 10:43 AM, the Corporate Regional Director stated activities were to be provided seven days per week. She stated a participation record was to be kept on all residents attending activity programs. She stated if a resident was not receiving activities on the weekends there was a possibility a resident may become bored and may affect the resident's quality of life. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/24/24 11:10 AM, the Activity Director stated she was not aware of the CMS Federal guidelines for the activity department. She stated she read the activity policy few years ago, however, did not recall what the policy stated about weekend activities or participation records. She stated it was very difficult to find volunteers to come to the facility on weekends. She stated she did have dominoes, puzzle books, cards, etc. available in the dining area for the residents to do on the weekends. The Activity Director stated not all residents was physically able to do puzzles, dominoes or play cards. She stated if a resident was not able to do these type of activities they would not have anything to do on the weekends. She stated she had an assistant and was no longer working at the facility approximately 3 weeks ago. The Activity Director stated she had been an activity director at the facility at least 3 years. Activity Director stated she did not ask the residents about weekend activities. Activity Director stated there was a possibility a resident may become bored, depressed , lonely if they did not have any activities on the weekends. She stated the facility had a new Administrator approximately 3 weeks. She stated since he had been at the facility she did not have the opportunity to discuss her concerns in the activity department and the weekend activities was one of her concerns. She stated it was her responsibility to ensure all residents received activities they enjoyed and met their individual preference. She stated if an activity occurs she was to document it on the participation records. The Activity Director stated she made copies of the monthly calendar and documented each resident on a separate calendar. She stated she highlighted the activity the resident attended on their personal calendar she kept in a binder. The Activity Director stated she did not document participation records anywhere but on the calendar in the binder she gave to the surveyor, and this had been her participation record system for three years. Activity Director stated she did not document participation records in the computer. She stated residents not receiving activities on weekends the resident may have a decline in their mood, cognition, and overall life. The Activity Director stated she did not recall over the past year of doing any in services with the nursing department about doing activities on the weekends. She stated if there were not any times on the calendar the residents would not know what time to attend the activity. The Activity Director stated it would be difficult for some residents to go outside and socialize and she did not provide an alternative activity for the residents unable to go outside. She stated activity of choice was when the residents did what they wanted to do in their rooms. The Activity Director agreed this was not a group activity and she understands how this may be confusing to the residents. In an interview on 10/24/2024 at 11:45 AM, Resident # 5 stated she had someone to visit on the weekends but sometimes she wanted to do an activity to socialize with other people. She stated sometimes it seemed lonely at the facility because there were no activities and nothing for the residents to do. Resident #5 stated they had activities during the week but did not have any on weekends this month. Resident #5 stated she did not want to discuss any-more about activities. In an interview on 10/24/2024 at 12:15 PM, Resident #16 stated she did become sad sometimes on the weekends and lonely but did not have these feelings during the week. She stated there were activities during the week but on the weekends during this month there was not any activities and sometimes she became bored and tired of watching television. Resident #16 stated she did not like to play dominoes or wanted to do puzzles. She stated she did not recall the activity director asking her what she would prefer to do on weekends. Record review of the Activity Director Personnel Record she had been an Activity Director for [AGE] years at this facility and she did have her current Activity Certification. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Facilities Policy on Activity Programming, dated 2011, reflected The Activity director and staff will provide for ongoing Activity programs. Practice Guidelines: 1. Recreation programs are based on the interest and needs of the residents expressed through the Activity assessment. 2. Resident's or families expressed needs and interests are included in the development of programs. Input from residents may be done on an individual basis or may be discussed at Resident Council/ Group. 3. Activity programs are be designed (this is exactly how the policy is written) on resident's leisure interests and implemented to meet the needs (physical, cognitive, creative, social, spiritual, independent, and sensory) of the residents. 4. Programs will be geared to maintain functional ADLs, provide social interaction and, at the same time, protect residents from environmental over stimulation. 5. Those who cannot participate in group settings are provided individual programming. Inability to participate could include those who refuse to participate in activities, those who are in isolation, or 'physician ordered' bed rest. 6. Programming includes large groups, small groups, individual and independent opportunities. 7. Programs may take place in mornings, afternoons and/or evenings that span throughout the entire week. 8. Programs use various areas available in and out of the health care center. 9. The resident population is cognitive assessed routinely to determine the number of functional level programs needed. 10. The opportunity is provided for regular community outings/ trips. Programs are developed to include community resources and involvement within, as well as outside the health care center. Record review of the Facility Policy on Activity Participation Records, dated 2019, reflected The Activity Department will maintain accurate records of group and individual program participation for each resident. 1. Resident attendance in programs is recorded on a daily basis to reflect resident attendance and will be used as a source of information for recording the resident's progress or lack of progress in the progress note. 2. Each resident has separate participation record of group activities and/or individual attendance and participation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Active, passive, and refused is noted on the participation records. 4. Individual programs (one on ones) not the response to intervention by either a checklist or a narrative for each program or visit 5. Participation records stored in health care center per state regulation, but no fewer than five years.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50001

Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the need of 4 (Resident#55, #54, #56, and#268) of 6 residents reviewed for narcotic pharmacy services.

1.CMA (F) administered narcotics and did not document in the narcotic book after administering to the residents.

This failure placed residents at risk for inadequate therapeutic outcomes, ineffective disease management and a decline in health.

The findings included:

Review of Resident #55's face sheet, dated 10/23/2024 revealed an [AGE] year-old male admitted to the facility with an initial admitted [DATE] and a admitted [DATE] with the following diagnosis: Gerstmann-Straussler-Scheinker Syndrome (GSS) is an extremely rare, always fatal (due to it being caused by prions) neurodegenerative disease that affects patients from 20 to [AGE] years in age, Adjustment disorder with depressed mood, mild cognitive impairment of uncertain or unknown etiology, anxiety disorder (Unspecified), nontraumatic intracerebral hemorrhage in hemisphere (cortical), cerebral amyloid angiopathy (CAA) happens when amyloid (abnormal) proteins build up in blood vessels in your brain. The proteins damage your blood vessels and cause bleeding inside your brain. The condition is the most common cause of cognitive decline in people aged 60 and older, other abnormalities of gait and mobility, primary open-angle glaucoma a progressive eye disease that damages the optic nerve and causes vision loss., bilateral, indeterminate stage, unspecified dementia (Dementia is the loss of cognitive functioning that interferes with daily life and activities).

Review of Resident # 55's Quarterly MDS dated [DATE] reflected a BIMS score of 02. Which indicates severe cognitive impairment.

Review of Resident #55's Physician order revealed PHENobarbital Oral tablet 32.4 MG give one tablet by mouth two times a day related to other epilepsy.

Observation on 10/22/2024 at 11:37 AM, revealed CMA (F) administered PHENobarbital Oral tablet 32.4 MG to Resident #55 at 08:00 AM and the medication at had not been documented in the narcotic book after being administered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #54's face sheet, dated 10/23/2024 revealed an [AGE] year-old female admitted to the facility with an initial admitted [DATE] and a admitted [DATE] with the following diagnosis: Chronic respiratory failure with hypoxia, mild cognitive impairment of uncertain or unknown etiology, noninfective gastroenteritis (is inflammation of the stomach and intestines, often caused by viruses, bacteria or chemicals) and colitis (Unspecified), major depressive disorder, recurrent severe without psychotic features, generalized anxiety disorder, morbid (severe) obesity due to excess calories, hyperlipidemia (abnormally high levels of fats (lipids) in the blood, which include cholesterol and triglycerides), other sleep apnea, essential (primary) hypertension, fibromyalgia (is a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues), other malaise (a general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify). Review of Resident # 54's Quarterly MDS dated [DATE] reflected a BIMS score of 05. Which indicates severe cognitive impairment. Review of Resident #54's Physician order revealed an order for Lyrica Capsule 150MG (Pregabalin) give one capsule by mouth two times a day for nerve pain. Review of Resident #56's face sheet, dated 10/23/2024 revealed an [AGE] year-old female admitted to the facility with an initial admitted [DATE] and a admitted [DATE] with the following diagnosis: Chronic Diastolic (Congestive) heart failure (a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs), Dysuria (is pain or discomfort when urinating), Atherosclerotic heart disease(Atherosclerosis is a hardening of your arteries from plaque building up gradually inside them) of native coronary artery without angina pectoris (Angina is chest pain or discomfort that happens when your heart isn't receiving enough oxygen-rich blood), major depressive disorder (single episode, moderate), Major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), recurrent severe without psychotic features, Dysphagia (difficulty swallowing), oropharyngeal phase, Other lack of coordination, Cognitive communication deficit, Pain (Unspecified), Unspecified protein caloire malnutrition, hyperlipemia (medical term for abnormally high levels of fats (lipids) in the blood), Essential (primary) hypertension (common condition that can damage your arteries and lead to serious complications), Cerebrovascular disease (term for conditions that affect blood flow to or within the brain), Muscle weakness (generalized), chest pain (unspecified), personal history of transient ischemic attack (brief stroke-like attack wherein symptoms resolve within 24 hours) and cerebral infarction (stroke is a life-threatening condition that happens when part of your brain doesn't have enough blood flow) without residual deficits. Review of Resident # 56's Quarterly MDS dated [DATE] reflected a BIMS score of 06. Which indicates severe cognitive impairment. Review of Resident #56's Physician order revealed an order for APAP/Codeine TAB 300-30MG give one tablet three times daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #268's face sheet, dated 10/23/2024 revealed an [AGE] year-old male admitted to the facility with an initial admitted [DATE] with the following diagnosis: Hypertensive heart disease with heart failure, Type 2 diabetes mellitus without complications, mixed Hyperlipemia (abnormally high levels of fats in the blood), Depression (Unspecified), Anxiety disorder (Unspecified), Occlusion and stenosis of right middle cerebral artery, Hemiplegia (form of paralysis that affects one side of the body) and hemiparesis (is weakness or paralysis on one side of the body caused by stroke) following cerebral infarction affecting left non-dominant side, Gastro-esophageal reflux disease (a digestive disorder that causes heartburn and acid indigestion) without esophagitis (inflammation of the esophagus), sacroiliitis (inflammation of the sacroiliac joint), radiculopathy (can cause pain, numbness and tingling along a pinched nerve in your back), lumbar region. Review of Resident # 268's Quarterly MDS dated [DATE] reflected a BIMS score that was not given because the MDS was still in process and had not been completed during the survey visit. Review of Resident #268's Physician order revealed Lyrica oral capsule 75MG (Pregabalin) give one capsule by mouth two times a day for nerve pain. Observation on 10/22/2024 at 11:37 AM, revealed CMA (F) administered Lyrica Capsule 150MG (Pregabalin) at 8:00 AM to Resident #54 and the medication had not documented in the narcotic book after being administered. Observation on 10/22/2024 at 11:37 AM, revealed CMA (F) administered one tablet of APAP/Codeine TAB 300-30MG to Resident #56 and the medication had not been documented in the narcotic book after being administered. Observation on 10/22/2024 at 11:37 AM, revealed CMA (F) administered Lyrica oral capsule 75MG (Pregabalin) to Resident #268 and the medication had not been documented in the narcotic book after being administered. During an interview on 10/22/2024 at 11:42 AM, CMA (F) stated that she did not log the narcotics in the book after administering them because she forgot today. CMA (F) voiced this could lead to a med error and acknowledged it could harm the resident. CMA (F) verbalized that another CMA or Nurse can come along after her and think the resident did not get the medication and administer it again to the resident. CMA (F) said she can't recall the last time she was in-serviced on documenting narcotics or medications after they are administered but she feels like they get in-services a lot. During an interview on 10/23/2024 at 11:22 AM, the DON stated that adverse effect of the act of CMA (F) could be the resident receiving too much medication because staff would not know that the resident already received their narcotic medication. This would lead to a med error voiced the DON. DON voiced her expectations are for staff to document in the narcotic count sheet in the narcotic book and acknowledge the medication has been given in the electronic medical record. When the correct steps are completed a progress note is populated in the electronic medical record and staff are to document resident response to the medication at the time of administration. Also, DON stated that an in-service would be performed for narcotic administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Medication Administration Procedures Pharmacy Policy & Procedure Manual 2003, Policy Statement reflected After the resident has been identified, administered the medication and immediately chart doses administered on the medication administration record. It is recommended that mediations be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration. Initials are to be used.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50001 Based on observations, interviews, and record review the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 8.57 % based on 3 errors out of 35 opportunities, which involved 1 of 8 residents (Resident #34) and 1 of 2 staff (CMA F) reviewed for medication errors, in that: The facility failed to ensure residents were free from medication errors. These failures could place residents at risk of medication errors that could cause a decline in health. Findings included: Record Review on 10/23/2024 of Resident #34's face sheet dated 10/24/2024 reflected Resident #34 was a [AGE] year-old male with an admitted [DATE]. Resident #34's diagnoses included: Posterior reversible encephalopathy syndrome, Parkinson's disease without dyskinesia (without mention of fluctuations), major depressive disorder (recurrent, moderate), anemia (unspecified), Type 2 diabetes mellitus without complications, bipolar disorder (unspecified), essential (primary) hypertension. Record Review on 10/24/2024 of the most recent MDS assessment dated [DATE] reflected Resident #34 had a BIMS score of 12 indicating Resident #34 was moderately cognitively impaired. Record review on 10/24/2024 of Resident #34's clinical physician orders revealed: Procardia XL Oral Tabled Extended Release 24 Hour 30 MG (Nifedipine) Give 30 mg by mouth two times a day for HTN hold if systolic is less than 120, and Hr less than 60. Record review on 10/24/2024 of Resident #34's clinical physician orders revealed: Chlorthalidone Tablet 25 MG Give 1 tablet by mouth one time a day for edema, hypertension. Record review on 10/24/2024 of Resident #34's clinical physician orders revealed: Toprol XL Oral Tablet Extended Release 24 Hour 100 MG (Metoprolol Succinate) Give 100 mg by mouth one time a day for HTN Hold for SBP less than 110 or DBP less than 60. CMA (F) administered 1 medication which was ordered to be given if blood pressure reading was within the parameters. Orders indicated to hold (don't give to resident) if blood pressure reading is outside of the parameters. The blood pressure was outside of the parameters. CMA (F) should have held the medication. CMA (F) documented that she gave a medication that she did not give, and she documented she did not give a medication that she did give to the resident. During an observation on 10/23/2024 at 07:46 AM, CMA (F) was observed passing medication to Resident # 34 which included 3 medications (Nifedipine tab 30 MG, Chlorthalid tab 25 MG and Toprol XL Oral Tablet Extended release 24-hour 100 MG) that were ordered by the physician to be given if blood pressure reading was within the parameters given. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/23/2024 at 07:46 AM, CMA (F) was observed obtaining Resident #34 blood pressure and it was: 102/71 with a HR of 70. The physician order for medication parameters read: Procardia XL Oral Tabled Extended Release 24 Hour 30 MG (Nifedipine) Give 30 mg by mouth two times a day for HTN hold if systolic is less than 120, and Hr less than 60. Chlorthalidone Tablet 25 MG Give 1 tablet by mouth one time a day for edema, hypertension. Toprol XL Oral Tablet Extended Release 24 Hour 100 MG (Metoprolol Succinate) Give 100 mg by mouth one time a day for HTN Hold for SBP less than 110 or DBP less than 60. Per physician order CMA (F) was not supposed to administer the Nifedipine because it was outside the parameters per the physician's order. CMA (F) verbalized that she did not give the Toprol XL oral Tablet because it was outside of the parameters but upon checking the residents record after the administration, CMA (F) documented she did give the medication. Upon observation on 10/23/2024 CMA (F) administered the Chlorthalidone Tablet 25 MG but documented she did not give it because it was outside of the parameters as indicated in the order. During an interview on 10/24/2024 at 11:22 AM, the DON stated it is her expectation that medications be given to residents as ordered by the doctor. She stated if a medication is ordered to be given within certain blood pressure parameters staff are to follow the instructions and administer accordingly. She stated she would have concerns if a medication as given outside of the parameters it could lead to a medication error. She stated she will provide an in-service to staff on medication administration and the 10 rights of medication administration. Record Review on 10/24/2024 of the Medication Administration Policy (Pharmacy Policy & Procedure Manual 2003) provided by the DON, revealed the following: Comprehensive care plan #13. When ordered or indicated, include specific item(s) to monitor (e.g., blood pressure, pulse, blood sugar, weight) frequency (e.g. , weekly, daily) timing (e.g., before or after administering the medication), and parameters for notifying the prescriber. # 15. Medication errors and adverse drug reactions are immediately reported to the resident's Physician. In addition, the Director of nurses and/or designee should be notified of any medication errors. Any medication error will require a medication error report that includes the error and actions to prevent reoccurrence. #20. The 10 rights of medication should always be adhered to: 1. Right patient, 2. Right medication, 3. Right dose, #4. Right route, #5. Right time, #6. Right patient education, #7. Right documentation, #8. Right to refuse, #9. Right assessment, #10. Right evaluation.

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 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd College Station, TX 77845

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(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. 50001 Based on observation, interview, and record review the facility failed to ensure storage of medications used in the facility in accordance with currently accepted professional principles and include the appropriate -The medication cart for the 400 halls had four unidentified loose pills. -The facility failed to ensure expired medications were removed from the medication carts and medication room. These failures could place residents at risk of not receiving the intended therapeutic effect of the medications or a contaminated medication. The findings were: Observation of medication cart for the 400 halls on 10/22/2024 at 2:00 pm revealed one green round pill imprinted with the number 40 on it and three white oval pills with the letter F on one side and the number 91 on the other side in the top-left drawer. RN B was not able to identify the four loose pills. Observation on 10/23/2024 at 11:17 AM revealed the facility hall 400 Medication cart with an Advair Diskus Inhalation Aerosol Powder Breath Activated 250mg/50mcg with the expiration date of 05/23. Interview with RN B on 10/22/2024 at 2:10 pm voiced that all four loose pills would be destroyed because she doesn't know who they belong to. The pills were immediately placed in the biohazard bin attached to the nurse cart. RN B voiced she thinks the pills may have gotten to the bottom of the cart and outside the pill packet because sometimes the packets are punctured and that would cause the pills to fall out. RN B verbalized that sometimes she has seen pills on the bottom of the cart. RN B voiced the facility can't really do anything to prevent it from happening. Interview with DON on 10/23/2024 at 11:22 am verbalized loose pills don't need to be on the bottom of the carts. DON voiced if a nurse doesn't find a pill after they notice it missing and can't locate it in the cart, it would eventually lead to an issue. When asked what kind of issue. DON voiced someone could grab it accidentally and give it to another resident. She emphasized that a resident would not be able to get into a cart, that issue would be more of a concern for another employee, giving a pill to another resident. DON verbalized that she thinks the pills that been in there for a long time tend to get loose adhesives on the backings of the pill packets and that is why the pills fell out. DON voiced sometimes it could be a manufacturing issue or they have received the pill packets from pharmacy with loose adhesives in the past and they have sent them back to send sealed packets back to them. DON voiced audits on carts are done weekly and weekly audits are done for medication rooms too. More thorough audits are conducted monthly. DON verbalized that if a nurse found loose pills on the bottom of their carts she would expect them to dispose of it in the bio-hazard or they can come to her office so they can dispose of the pills using the drug buster. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd College Station, TX 77845

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(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	Observation on 10/22/2024 at 1:58 PM revealed the facility medication room with a bottle of Aspirin with an expired date of 09/24 and a bottle of Daily Vitamin formula and Iron with an expired date of 08/24. In an interview on 10/23/2024 at 11:19 AM with CMA (K), when asked if the resident that the expired inhaler is still a resident in the facility. CMA(K) acknowledged yes, resident still lives here and still uses the inhaler. CMA (K) verbalized she checks her cart for expired medications periodically. There is not a time period for checking the dates, staff just need to remember to check the dates. When CMA (K) was asked what some potential adverse effects could happen to the resident if they are given an expired inhaler. CMA (K) voiced the medication will not work properly. CMA (K) could not remember the last time she received an in service on checking carts for expired medications. In an interview on 10/24/2024 at 01:43 PM, DON verbalized that the medication room is audited weekly, and all medications should be discarded if expired. The DON verbalized she is responsible for the audits and pharmacy and staff do them too. DON verbalized she would not expect her staff to administer an expired inhaler to a resident. The potential adverse effects if a resident received an expired inhaler would be the resident would not get the maximum benefit of the medication if it is expired. It could lead to respiratory depression or other complications. The DON voiced that the CMAs are supposed to be checking their carts for expired medications on a regular basis and she does spot checks for expired medications. Review of the facility's Policy Medication Administration Procedures Policy does not specify when staff should check for expired dates. The policy does not specify or include anything related to ensuring residents do not get expired medications.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortress Nursing and Rehabilitation	1105 Rock Prairie Rd College Station, TX 77845

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(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.

50176

Based on observations, interviews, and record reviews, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation.

The facility failed to ensure the Director of Rehabilitation/PT and LVN D were wearing effective hair restraints, while in the kitchen.

This failure could place residents who received meals and/or snacks from the kitchen at risk of foodborne illness due to physical contamination.

Findings included:

During an observation of the dining room on 10/22/2024 at 11:55 AM, LVN D walked in and out of the kitchen three different times to get meal trays without wearing a hair restraint.

An observation of the kitchen on 10/22/2024 at 12:59 PM, revealed the Director of Rehabilitation/PT was in the kitchen by the steamtable. The Dir Rehab had long hair past her shoulders and was not wearing a hair restraint.

During an interview with the Dir Rehab on 10/23/2024 at 7:46 AM, she stated that she was in the kitchen on 10/22/2024 and was not wearing a hair restraint. She stated there was a policy that required hair restraints in the kitchen, but she thought that was not needed for the front area of the kitchen on the front side of the steamtable. She stated that hair restraints were needed to avoid hair getting in the residents' food, which could cause a negative outcome to residents getting sick.

During an interview with the DM on 10/23/2024 at 7:50 AM, she stated she received training on proper hair restraints before she started work and was in-serviced with web-based training. She stated that hair restraints were important in the kitchen to avoid hair getting in the residents' food, which could make them sick or vomit. Her expectation was for staff to wear hair nets in the kitchen, but she did not think the front area of the kitchen on the other side of the steamtable was considered the kitchen area and was not concerned that staff did not wear hair nets in that area. She stated that there was a plastic shield/ plexiglass on the steamtable that protected food. She stated that a sign about hair restraints used to be posted on the wall outside the kitchen, but it fell off and had not been replaced. The Director of Food and Nutrition pointed to a yellow sign on the kitchen interior door by the ice machine and steamtable that read, Dietary Employees Only Beyond This Point Thank You. Ring Bell for Assistance.

During an interview with dietary aide on 10/23/2024 at 7:53 AM, she stated she received training on proper hair restraints before she started work. During the training, she learned everyone had to wear a hair net while in the kitchen.

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NAME OF PROVIDER OR SUPPLIER Fortress Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 Rock Prairie Rd College Station, TX 77845	

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(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	During an observation of the kitchen and outside the kitchen area on 10/23/2024 at 8:00 AM, there were no signs regarding hair restraints. There was a container of hair restraints available on a table next to the main kitchen door. During an interview on 10/23/2024 at 11:03 AM, the [NAME] stated that she received training in hair restraints before she started work. She stated everyone must wear hair restraints all the time while in the kitchen. The [NAME] stated hair restraints were required to avoid cross-contamination of getting hair into resident food, which could make them sick. During an interview with the ADMIN on 10/23/2024 at 2:08 PM, he stated that he was new and had only been at the facility for three weeks. He did not know what the facility's policy was regarding staff entering the kitchen or wearing hair restraints. He was not sure what his expectation regarding staff entering the kitchen or the use of hair restraints would be. During an interview with the DON on 10/23/2024 at 2:15 PM, she stated that the facility's policy was all staff entering the kitchen must wear a hair net/hair restraint. She stated potential negative outcome for residents was that staff's hair could get into the food and cause contamination. Her expectation was that her staff would not enter the kitchen, but rather stand at the door and ask for assistance. If her staff needed to enter the kitchen, her expectation was that staff would wear a proper hair restraint and wash their hands. During a telephone interview with LVN D on 10/23/2024 at 2:26 PM, she stated it was the facility's policy that all staff entering the kitchen must wear a hair net/hair restraint. LVN D stated on 10/22/2024 during lunch, she helped in the dining room and was asked to enter the kitchen to get meal trays. She did not think about putting on a hair net. She knew that she should have, but she forgot. She stated that hair restraints were important to keep food sanitary. She stated there was a potential for hair or dandruff to get in food without a hair restraint and that could make residents sick and they could vomit. Record review of the 2022 Food Code; Section 2-402 Hair Restraints, from the United Stated Food and Drug Administration, revealed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that were designed and worn to effectively keep their hair from contacting exposed food. Record review of the facility's Dietary Services Policy and Procedures Manual 2012 HR 00-2.0 titled Dietary Food Service Personnel Policy and Procedures under Sanitation and Food Handling revealed: Hair nets or hats covering the hairline are worn at all times.