STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on interviews and record reviews, the facility failed to ensure a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (Resident #37) of 3 residents reviewed for pressure ulcers. The facility failed to notify Resident #37's physician and modify his interventions when he refused to wear his protective boot on his left foot and when he refused to be repositioned in bed. The facility failed to accurately assess and modify interventions for Resident #37, whom the facility said prefers to lie on his abdomen, and he had a suprapubic catheter. Resident #37 developed a stage 4 pressure ulcer on his left medial foot and on left abdomen and right groin. An IJ was identified on 01/24/24. The IJ template was provided to the facility on [DATE] at 3:00 p.m. While the IJ was removed on 01/26/24 at 3:55 p.m., the facility remained out of compliance at a scope of pattern and a severity of no actual harm with potential for more than minimal harm that was not immediate jeopardy, because all staff had not been trained on reporting and assessing for changes of condition. These failures placed residents at risk for new development or worsening of existing pressure injuries, infection, pain, and decreased quality of life. Findings included: Record review of Resident #37's face sheet dated 01/03/24 revealed a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #37 had diagnoses which included cardiac arrest (heart suddenly stops pumping), muscle wasting and atrophy (a condition in which muscles begin to waste away due to disuse), paraplegia (inability to voluntarily move lower parts of the body), dependence on renal dialysis (removing of waste and excess fluid from the body with kidney failure) and peripheral vascular disease (a slow and progressive circulation disorder). Record review of Resident #37's quarterly MDS assessment, dated 11/20/2023, revealed a BIMS score of 15 out of 15, which indicated the resident's cognition was intact. Further review of Resident #37's MDS revealed the resident developed a pressure ulcer after admission. The intervention for the pressure ulcer such as pressure reducing device for bed, turning, and/or repositioning program was not indicated. (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
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #37's undated care plan revealed: Resident #37 developed a stage 4 pressure ulcer on left medial foot. Interventions: administer treatments as ordered and monitor for effectiveness, offload pressure as much as possible. Further review of Resident #37's care plan revealed Resident #37 had an actual impairment to skin integrity related to non - pressure wounds on: left abdomen, and right groin. Interventions: educate resident on the importance of turning and repositioning, treatment per MD orders. It also read the resident desires to lay on his stomach. Record review of Resident #37's admission/readmission skin evaluation dated 07/11/23 revealed Resident #37 did not have any skin issues on his left foot, or any skin issues on his abdomen or groin. Record review of Resident # 37's Braden scale dated 11/7/23 revealed resident was at high risk for a pressure ulcer and further review revealed the resident had very limited mobility: could make slight changes in body or extremity independently. Record review of Resident #37's weekly skin evaluations from 08/28/23, 09/05/23, and 09/11/23 did not reveal the resident had any skin issues on the left medial foot. Record review of Resident #37's weekly skin evaluation dated 9/19/23 revealed a stage 4 pressure ulcer was first observed on the resident's left medial foot and it measured 1.0 X 1.0 cm. Record review of Resident #37's weekly skin evaluation from 12/11/23 and 12/18/23 did not reveal the resident had any skin issues on the left abdomen or right groin area. Record review of Resident #37's wound evaluation and management summary report for the left medial foot by the wound care doctor dated 09/19/23 described the wound duration greater than 13 days, measured 1.0 X 1.0 cm at stage 4 with thick adherent devitalized necrotic tissue (this tissue cannot be savaged and must be removed to allow wound healing to take place). The wound was debrided. Record review of Resident #37's wound evaluation and management summary report for the right groin by the wound care doctor dated 12/26/23 described the wound duration greater than 1 day, measured 2.5 X 2.5 X 0.1 cm, light serous and 100 % granulation tissue (the stage for epithelial tissue to be laid on of a wound bed). Record review of Resident #37's wound evaluation and management summary report for the left abdomen by the wound care doctor dated 12/26/23 described the wound duration greater than 4 days, measured 2.0 X 2.0 cm depth was not measurable due to presence of nonviable tissue and necrosis. The non pressure wound was debrided. Record review of Resident #37's physician order date January 2024 revealed the following orders: cover suprapubic catheter port with an island border gauze every night shift on Sunday, offload wound as resident would allow, float heels in bed as the resident would allow, reposition as resident would allow was started on 01/04/24. Record review of Resident #37 physician order date January 2024 read pressure wound stage 4 of left foot medial, cleanse with NS/WC pat dry, apply collagen powder, and cover with an island border gauze. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #37's order summary report dated January 2024 revealed the following orders: cover suprapubic catheter port with an island border gauze every night shift on Sunday, offload wound as resident would allow float heels in bed as the resident would allow, and reposition as resident would allow was started on 01/04/24. Record review of Resident # 37's progress notes dated 12/22/23 revealed entry by the wound care nurse which read in part during routine wound care resident was observed to have an unstageable pressure wound to the left stomach related to pressure applied to the resident by laying on the catheter . Record review of Resident #37's progress notes from 12/05/23 to 01/04/24 did not reveal any documentation of Resident #37's refusal for turning and repositioning, physician notification of Resident # 37 refusal to wear the boot on his left foot, alternate intervention in place, or any education given to Resident #37. During an interview on 01/03/23 at 9:15 a.m., the Wound care nurse said Resident # 37 had a wound on the left medial foot because he refused to wear the boot on his foot. Resident #37 laid on his abdomen because that was the only way he could lay down. He had stage four pressure ulcer on both ischia and Resident#37 was admitted to the facility with two wounds. The wound care nurse said he had been lying on his abdomen since she became the wound care nurse about four months ago. The Wound care nurse said she found the wound on Resident #37's left abdomen on 12/22/23 when she made her usual wound rounds. The wound on the right groin was discovered when she made wound rounds with the wound care doctor and the wound care doctor said the non-pressure wound was from the catheter tubing. She said there was no intervention in place before and after the wound occurred. The wound care nurse said she did not call Resident #37's physician and told him that Resident #37 preferred to lay on his abdomen because this was on going before she became the wound care nurse. During an interview on 1/3/24 at 4:35 p.m., the DON said Resident #37 likes to lie on his abdomen. The DON said the staff tried encouraging him to lie on his sides and back, but he would not. The DON said she had to investigate his plan of care to find out if there was an intervention put in place since the resident had a suprapubic catheter and preferred to lie on his abdomen. The DON said she did not notify Resident #37's physician that the resident chose to lay on his stomach. She was not sure if any alternative intervention was put in place by the nurses before Resident #37 developed the two non -pressure wounds. The DON said the nurses do the weekly skin assessment, and the wound care nurse does the wound assessments. The DON said the wound care nurse and the nurse managers were responsible for putting interventions in place and education the nursing staff. The DON did not respond when she was asked what a negative outcome for Resident #37 could be when she was not turned and repositioned. During an interview on 1/4/23 at 8:30 a.m., the DON said that Resident #37 wanted to get up, and the wound care nurse was ready to provide the wound treatment. The state surveyor told the DON she was on her way to observe the wound care treatment. During an interview on 01/04/24 at 8:38 a.m., the DON said the ADON told her that Resident #37 did not want the state surveyor to observe his wound care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/04/24 at 3:46 p.m., the Wound Care doctor said Resident #37 preferred to sleep on his abdomen and did document that on his notes. He communicated to the nursing staff about turning and repositioning Resident #37. The Wound care doctor said the two non-pressure wounds were caused by Resident #37 laying on the tube. He stated Resident#37 had an air mattress, and he was not aware if an alternate intervention was put in place to prevent the wounds. The wound care doctor said the unstageable wound could develop within four hours from the tubing, without showering, any sign of skin breakdown or discoloration, and he thinks the facility did all they could do for Resident #37. During an interview on 01/4/24 at 3:54 p.m., ADON L said Resident #37 laid on the suprapubic tube while he was lying on his abdomen, and it had been ongoing since she started to work in the facility. ADON L said the areas (left abdomen and right groin) developed non-pressure wounds. ADON L said the staff told her Resident #37 refused to turn, she did not call Resident #37's physician or educate the resident. The facility did not have any other intervention except for turning and repositioning in place before and after the wound developed. ADON L said after the wound care nurse talked to the state surveyor, they put in a new order to wrap the Suprapubic catheter tubing to prevent it from touching the resident's skin. ADON L said the nurse management monitors the nurses when they make random rounds and in - service on catheter. ADON L the Wound Care Nurse and nurse managers were responsible for modifying intervention and when asked while there was no intervention in place when the staff was aware Resident #37 preferred to lay on his, ADON L did not respond. During an interview on 01/04/24 at 3:58 p.m., the Wound care nurse said she initiated an order yesterday (01/03/24) to wrap the tubing weekly to prevent the tubing from coming in contact with Resident #37's skin. During an interview on 01/04/24 at 4:04 p.m., the wound care nurse said Resident #37 was supposed to wear a boot on his left foot, and he refused to wear the boot. The wound care nurse said there was no other intervention put in place since Resident #37 declined the boot. She stated this could have contributed to the development of the pressure ulcer because the foot may not have been relieved from pressure. The wound care nurse said she did not tell the DON or the resident physician that Resident # 37 refused to wear the boot on his foot or document the refusal. The wound care nurse said the wound on Resident #37's left medial foot started on September 19th, 2023. The wound care nurse said the nurse does the head-to-toe assessment, and she does the wound assessment. The wound care nurse said she did not notice any change in color on Resident # 37's left medial foot until she was made aware of the wound. The wound care nurse said she did not offer to float Resident #37's left foot on a pillow because there was no order to float his foot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/04/24 at 4:09 p.m., the DON said the staff told her that Resident #37 refused to turn and preferred to lay on his abdomen. The DON said she did not educate Resident #37, but the nurses said they educated him. The DON said she did not call Resident #37's physician to inform him about the resident's refusal to turn and reposition and that he preferred to lie on his abdomen. The DON said she was the wound care nurse for the facility about two years ago. She used to prop Resident #37 legs on pillows and Resident #37 had no problem with it at that time. She was not aware he refused to wear the boot. The DON said she had told the nurses to use pillows to elevate Resident #37's leg, and she did not know why the nurses did not do it. The DON said she would research and see if the nurses documented that Resident #37 refused to elevate his legs even with a pillow and if Resident #37's physician was notified about his refusal before he developed the pressure ulcer and non - pressure Ulcer. The DON said she would research and see if the nurses documented that Resident #37 refused to turn and reposition and if the nurses notified Resident #37's physician about his refusal before he developed the non-pressure wounds. The DON said she was still determining if the facility implemented any intervention other than turning and repositioning. The DON said the areas could develop non-pressure wounds if pressure was not relieved. During an interview on 01/05/24 at 12:36 p.m., LVN M said Resident #37 refused to turn on his side, but he does turn for her. LVN M said she would go back to the resident's room about 30 minutes later, and he would go back to his abdomen. LVN M said she was unsure if any intervention was put in place since he preferred to lie on his stomach. LVN M said she would call the NP and ask if there was any intervention to prevent the tube from giving the resident wounds. She was not aware the wound on his abdomen was from the Suprapubic tubing. LVN M said she did not tell Resident #37's physician about the resident's refusal and she did not respond when she was asked why she did not notify the physician. LVN M said there was no alternative intervention in place to prevent the non-pressure wounds, and she did not inform the DON of the resident refusal or document any refusal. LVN M said Resident #37 gets up early in the morning and stays up throughout her shift (12 hours). LVN M said the nurse monitors the aides, and she had in-service and skills check-off on wound care and prevention. LVN M said the ADON monitored the nurse's when she made random rounds. During an interview on 01/05/23 at 1:46 p.m., CNA C said Resident #37 gets up in the morning at various times, and Resident #37 stays up through his shift. CNA C said he does not turn Resident #37 when he was in bed because Resident#37 turns himself and lies on a different side of his body. CNA C said Resident #37 wore a boot on his left foot, where he had a wound. CNA C could not remember if he started to wear the boot before or after Resident #37 developed a wound on his foot. CNA C said he provided incontinent care to Resident # 37 every two hours, and sometimes he showered the resident, and he did not notice any wound on his abdomen or groin area. CNA C said he came to work about two weeks ago and saw the patch(dressing) on the resident's abdomen. During an interview on 01/05/24 at 2:53 p.m., the DON said she could not find any refusal documentation for turning and repositioning Resident #37. The DON said there was no documentation that Resident #37's physician was notified of his refusal by the nurses. The DON stated there was no other intervention put in place to help prevent non-pressure and pressure ulcer wounds from developing, except Resident #37 had an air mattress. The DON said Resident #37 was started on zinc sulfate tablet 220 mg on 01/04/24 and other supplements. The DON said the facility does not do labs for Resident #37 because the dialysis center does his labs. She did not know what Resident #37's pre-albumin was. The DON said the dialysis should contact the facility if there were any issues with Resident #37's lab. The DON said she would contact the dialysis center and get back to the state surveyor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 1/5/24 at 4:47 p.m., LVN H said she started working on the second floor in December 2023. The aides usually turned Resident #37 every two hours and Resident #37 was changed every two hours. LVN H said Resident #37 also turns himself. LVN H said Resident # 37 was up most of the day, and she worked 6 a.m. to 6 p.m. LVN H said the aides had not complained to her that the resident refused to wear the boot. LVN H said Resident #37 was on the B bed, and the nurse assessed his skin at night. LVN H said there was no intervention put in place that she could remember to prevent or relieve Resident #37 from developing a pressure ulcer. LVN H said she did not notify Resident #37's physician about any refusal because she did not see any need for it because Resident #37 did not refuse to wear the boot or turn and repositioned on her shift. Record review of the facility policy on skin and wound monitoring and management dated 03/2015, revisions: 12/2019, 1/2022 read in part the purpose of this policy is that the facility provides care and services to . #1 . promote interventions that prevent pressure injury development . procedure C . identify risk factors which relate to the possibility of skin breakdown and/ or the development of pressure injury which include, but are not limited to: resident refusal of some aspects of care and treatment . prevention . #3b . monitor impact of intervention and modify intervention as appropriate . #8 response to resident choices that differ from plan of care #8a if the resident is not able to or chooses not to participate in the care plan to prevention of skin breakdown, or treatment of exiting wound . the nursing staff shall communicate with the resident's physician to discuss an appropriate intervention or response . if the resident's physician is unavailable, the nursing staff shall contact the medical director . This was determined to be an Immediate Jeopardy (IJ) on 7/29/23 at 6:16 p.m. The DON and Administrator were notified. The Administrator was provided with the IJ template on 01/24/24 at 3:00p.m. The following Plan of Removal submitted by the facility was accepted on 01/25/26 at 10:59 a.m.: The Medical Director was notified by the Executive Director on 01/24/2024 at 3:32 p.m. 1. The Attending Physician was notified by the Executive Director, of the IJ on 1/24/2024 at 3:32 p.m. 2. The Wound Care Specialist was notified by the Executive Director, of the IJ on 1/24/2024 at 3:53 p.m. 3. New Braden scales for the total census initiated 01/24/2024 and will be completed 01/24/2024 by Clinical Resources, Clinical Leaders MDS Nurse, ADON and DON. 4. Audit completed by DON on 01/24/2024 of all residents who are at risk for PU/PI, Care plans and care profiles were updated for all residents at high risk to include personalized/individualized interventions/prevention. This was also completed 01/24/2024. 5. Skin assessments were completed on all high risk Bradens 01/24/2024- no new areas were identified. These were conducted by the DON, ADON, MDS Nurse and Clinical Resource. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Education initiated 01/24/2024 by Clinical Resource with DON, ADON, Nurses, CMAs, and CNAs that included change in condition procedures for wounds, change in behaviors, refusal of care, turning and repositioning notification of changes in wounds, interventions and preventions, as well as communication between Nursing staff and health care professionals; will be completed by 1/25/2024. Any staff unable to attend will not be allowed to work unless they have received their training and knowledge check. 7. All licensed nurses will complete competency on skin assessments started on 01/24/24 and will be completed 01/25/2024 by DON, ADON, and Clinical Resource 8. All CNA's will complete competency on skin check started on0l/24/2024 and will be completed on 01/25/2024 by DON, ADON, MDS Nurse, and Clinical Resource 9. MDS Coordinator will be reeducated on proper coding of MDS 01/24/2024 o completed by Clinical resource 01/24/2024. 10. This training and competencies will be completed in-person with all staff prior to the start of their next shift. A member of management will be at the facility at each change of shift to ensure all staff complete training prior to going to work on the floor. Staff will not be allowed to work unless they have completed the training and competency checks. This training will also be included in the new hire orientation and will be included for any PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received their training and knowledge check. 11. An ad hoc QAPI meeting regarding items in the IJ template will be completed on 01/24/2024. Attendees will include the Medical Director, Clinical Resource, Administrator, DON, ADON, and will include the plan of removal items and interventions. 12. The DON, ADON or Clinical Resource will verify staff competency with 10 staff weekly using the skin check competency checklists. 13. All residents with pressure ulcers be reviewed during the weekly clinical meeting and the Medical Director will be consulted for any recommendations or suggestions as necessary. Meetings attendees to include but not limited to the DON, ADON, Rehab Director and Wound Nurse. The DON and Administrator will be responsible for ensuring this meeting is held weekly and all residents with pressure ulcers/pressure injury are reviewed. 14. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. 15. Resident #37 was reevaluated by the Wound Care Specialist on 1/23/2024, he does not recommend applying any appliances to the suprapubic site as this will increase the pressure to the site; resident will be encouraged to turn side to side as he tolerates or will allow. Resident has a low air loss mattress; wheelchair cushion when up and heels are to be floated when he is in the bed as he will allow. RD and Therapy will reevaluate for any other interventions, completed by 1/25/2024. Psych evaluation to be scheduled, resident consented 1/25/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor monitored the plan of removal for effectiveness as follows: Record review of the plan of removal #15 read Resident #37 was reevaluated by the Wound Care Specialist on 1/23/2024, and he does not recommend applying any appliances to the suprapubic site as this will increase the pressure to the site; resident will be encouraged to turn side to side as he tolerates or will allow. Resident has a low air loss mattress, wheelchair cushion when up, and heels are to be floated when he is in the bed as he will allow. RD and Therapy will reevaluate for any other interventions completed by 1/25/2024. The psych evaluation is to be scheduled; the resident consented on 1/25/2024. Record review of in-service records dated 1/24/24 revealed the MDS Coordinator was trained on proper coding of MDS. Record review of in-service records dated 1/24/24 and 1/25/24 revealed Multiple nurse aides from multiple shifts completed competency checks on skin checks during care. They reported to the nurse if there were any skin issues and documented on-point click care. In service on prevention and interventions: turning and repositioning resident in the bed and wheelchair every two hours and report to the nurse if resident refused and document on point click care. Record review of in-service records dated 1/24/24 and 1/25/24 revealed. Multiple nurses from both shifts completed competency checks on the Braden scale: done on admission, weekly for four weeks, and whenever there was a change in skin condition. Skin assessment is started on admission and weekly by the charge nurse, who reports any change in skin condition to the resident's physician. In service on prevention of pressure ulcers, turning and repositioning and reporting any refusal to the physician and documenting on residents' progress notes, also reporting to nurse managers of any refused intervention, and the resident responsible party should be notified. The nurse managers would update the care plan. Record review of the Braden scale revealed that 15 Residents were documented as having a high or very high risk for developing pressure ulcers. Record review of skin assessments revealed that the DON, ADON, MDS Nurse, and Clinical Resource completed the evaluation on all high-risk Braden 01/24/2024, and no new areas were identified. Interviews on 01/25/24 with four nurses (2 LVN and 2 RN) between 12:44 p.m. and 2:38 p.m. on the above training: Braden scale should be done upon admission, weekly for 4 weeks, and quarterly, and when there was a change in any skin condition. They were also in service on weekly skin assessments, notifying resident physicians about any change in a resident's skin condition or refusal of skin intervention, and documenting in the resident progress note. They said the nurse should notify nurse management of any refusal and any change or modification of intervention so that it would be updated in the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews on 01/25/24 between 2:00 pm and 2:19 pm, two-day staff (CNAs) were interviewed, and they said they were in serviced and trained on skin check: they should check the resident's skin during all care and notify the charge nurse if there was any skin impairment and document on point click care. They also said they were trained on measures to prevent pressure ulcers: turning and repositioning every two hours, floating heels on the pillow, reporting to the nurse if any resident refused, and documenting the refusal on point clock care. All interviewed staff expressed understanding of the training provided above. Interview on 01/25/24 at 1:24 p.m., ADON E said she was retrained and had in service on the facility's Braden scale, skin assessment, resident physician notification for refusal, intervention modification, and updating care plan. She expressed understanding of the plan of removal training provided to her. Interview on 1/25/24 between 7:29 p.m. and 7:50 p.m., two nurses (LVNs night shift) were interviewed on the facilities in service and training on skin assessment, intervention, and reporting to a resident physician about change in skin condition, refusal of intervention, and documentation. All staff interviewed expressed adequate understanding of the plan of removal training provided to them. Interview on 1/25/24 between 8:00 p.m. and 8:33 p.m., five-night staff (CNAs) were interviewed on the facility in-service and training on skin assessment, intervention, and reporting to a resident physician about change in skin condition, refusal of intervention, and documentation. All staff interviewed expressed adequate understanding of the plan of removal training provided to them. Interview on 1/26/24 between 10:14 a.m. and 10:30 a.m., two nurses (LVNs) were interviewed on the above training: Braden scale should be done upon admission, weekly for 4 weeks, and quarterly, and when there was a change in any skin condition. They were also in-service on weekly skin assessments, notifying resident physicians about any change in a resident's skin condition or any refusal of skin intervention, and documenting on the resident progress note. They said the nurse should notify nurse management of any refusal and any change or modification of intervention so that it would be updated in the care plan. All staff interviewed expressed adequate understanding of the removal training plan provided to them. Interview on 1/26/24 between 10:35 a.m. and 10:50 a.m., two - staff (CNAs) were interviewed on the facility's in-service and training on skin assessment, intervention, and reporting to the resident nurse about changes in skin condition, refusal of intervention, and documentation. All staff interviewed expressed adequate understanding of the plan of removal training provided to them. Interview on 1/26/24 at 11:10 a.m., ADON L was interviewed on the facility in-service training on skin assessment, intervention, and reporting to a resident physician about changes in skin condition, refusal of intervention, and documentation, and updating the care plan. ADN L expressed adequate understanding of plan of removal trainings provided to them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 01/26/24 at 11:37 a.m., the MDS coordinator said she had training on Thursday on correctly coding interventions, and she also trained on pressure ulcers on Relias yesterday. The MDS said she uses UDA (user-defined assessment) and shows if the resident has a pressure ulcer. Then, she would interview the wound care nurse and the floor nurse about the resident's wound treatment and interventions. The MDS coordinator said she would also review the wound care doctors' notes and assess the resident. The MDS coordinator said these would determine how she would code for the resident after the assessment, interview, and record review. She said the care intervention is done as a team during IDT (interdisciplinary team} and morning meetings. The MDS coordinator said she was also told to consult with DON during the retraining when unsure of any intervention. Interview on 01/26/24 at 12:00 p.m., the DON said all the staff were retrained and in service on the Braden scale, skin assessment, reporting to the physician for any skin impairment, refusal of intervention and care, reporting to nurse managers and the managers with come up with a different or modified intervention and care plan it. She said the nurses and the aides were in service on documentation and notifying the resident responsible party. Interview on 01/26/22 at 12:10 p.m., the Administrator said all staff were in-serviced on the removal plan and the facility's new system. The DON will monitor as mentioned in the removal plan. The Administrator said he would oversee the plan of removal completion and implementation. On 01/26/24 at 3:55 p.m., the Administrator and the DON were notified the Immediate jeopardy was removed. However, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimum harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care and services, including oxygen administration was provided such care, consistent with professional standards of practice for 2 of 5 residents (Resident #6 and #26) reviewed for respiratory therapy. The facility failed to ensure Resident # 6's concentrator filter was covered and clean with a substantial amount of brown substance, undated nasal cannula, and the humidifier was empty and dated 12/17/23. The facility failed to follow the physician orders for Resident #26's oxygen administration and the nasal cannula was not dated. These failures placed residents who received oxygen therapy at risk of respiratory complications. Findings included: Record review of Resident #6's face sheet dated 01/03/24 revealed a [AGE] year-old male initial admitted to the facility on [DATE] and readmitted on [DATE]. Resident #6 had diagnoses which included shortness of breath (an intense tightening in the chest, air hunger or difficulty breathing), heart failure (heart that cannot keep up with its workload), chronic respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in the body) and chronic obstructive pulmonary disease (group of diseases that cause airflow blockage and breathing related problems). Record review of Resident #6's quarterly MDS assessment, dated 12/06/2023, revealed a BIMS score of 08 out of 15, which indicated the resident's cognition was moderately impaired. Further review did indicate he was on oxygen therapy. Record review of Resident #6's care plan dated 10/18/23 revealed: Resident #6 required oxygen therapy related to hypoxia. Interventions: change O2 tubing, and humidifier bottle every Sunday night shift. Record review of Resident #6's order summary report dated January 2024 read change O2 tubing, and humidifier bottle every Sunday night shift. 2L - 4L (liter) of 02 (oxygen) to keep 02 SAT (saturation) greater than 90% (percent) or greater every shift order dated 12/01/23. During an observation on 01/02/24 at 11:49 a.m., revealed Resident #6's concentrator filter on the back of the concentrator was covered with a substantial amount of brown substance. The humidifier bottle was dated 12/17/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 - Few	During an observation and interview on 01/02/24 at 11:52 a.m., LVN O said she saw the humidifier bottle was dated 12/17/23, and it was empty. LVN O said the nasal cannula was not dated, and she could not tell if it was changed weekly because it was not dated. LVN O said Resident #6's humidifier bottle and nasal cannula should be changed every Sunday by the nurse. LVN O said the filter was covered with dust and that the filter should be cleaned weekly and as needed. LVN O said the water gives Resident #6 moist air. LVN O said the filter should not have dust because it could cause respiratory problems for the resident. LVN O said the concentrator should be checked during rounds at least twice during the shift. LVN O said she did the walk-through with the night nurse during shift change but did not pay attention to the date on the humidifier or the filter. LVN O said without the moisture from the humidifier, Resident #6 would be breathing dry air. It could irritate Resident #6's nostrils, which could cause bleeding. LVN O said the unit manager monitors the nurses when she makes random rounds. During an interview on 1/04/24 at 11:16 a.m., LVN J said the nasal cannula and the humidifier bottle should be dated when it was changed weekly and PRN. This was done to make sure the nasal cannula and the humidifier were patent and there were no infection control issues. LVN J said Resident #6's concentrator, which required a humidifier, should have one to prevent Resident #6's nostrils from being dry and prevent bleeding. LVN J said if the filter was not cleaned, Resident #6 may breathe in the particles from the air, which could cause respiratory problems. LVN J said the filter should be cleaned weekly and as needed by the nurses. During an interview on 01/04/23 at 1:59 p.m., ADON E said the humidifier bottle and the nasal cannula for Resident #6 were scheduled to be changed on Sunday night, and it should be dated to show the nurse changed them. ADON E said the humidifier keeps the nostrils moist. When there is no moisture, it could cause the nostrils to become dry, which could cause irritation and bleeding for Resident #6. ADON E said the filter area on the concentrator should be cleaned, which makes the concentrator work better. ADON E said she does not know if a dirty air filter would affect air flow or have any adverse outcomes for Resident #6. She stated that it was the facility protocol to date the NC tubing and humidifier, which was changed weekly by the nurse. ADON E said if the NC was not changed, it could be kinked or clogged, and all the managers monitored the nurses when they made rounds. During an interview on 01/04/24 at 2:08 p.m., the DON said the nurses were responsible for checking the concentrator and ensuring the machine was functioning. The DON said the humidifier bottle and the oxygen tubing were changed and dated weekly and PRN. The DON said the humidifier bottle and the nasal cannula were changed and dated every week and as needed for patency and infection control issues. The DON said the air filter should be cleaned weekly and as necessary to help filter airborne contaminants. Resident #26 Record review of Resident #26's face sheet dated 01/03/24 revealed a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #6 had diagnoses which included heart failure (heart that cannot keep up with its workload), cardiomegaly (enlargement of the heart) and chronic obstructive pulmonary disease (group of diseases that cause airflow blockage and breathing related problems). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 - Few	Record review of Resident #26's quarterly MDS assessment, dated 12/08/2023, revealed a BIMS score of 15 out of 15, which indicated the resident's cognition was intact. Further review did indicate she was on oxygen therapy. Record review of Resident #26's care plan dated 09/11/18 revealed: Resident #26 receives oxygen therapy related to pulmonary edema and CHF (congested heart failure). Interventions: change O2 tubing and administer oxygen per MD orders. Record review of Resident #26's order summary report dated January 2024 read change O2 tubing, and humidifier bottle every Sunday night shift. 2L (liter) of 02 (oxygen) to keep 02 SAT (saturation) at 90% (percent) or greater for SOB (shortness of breath) order dated 04/15/23. During an observation and interview on 01/02/24 12:38 p.m., it revealed Resident # 26's oxygen was set at 5 L, and the nasal cannula was not dated. Resident #26 said her oxygen should be set at 2L, and she changed the setting about two weeks ago when she had a panic attack. Resident #26 said the nurses do not come and check her oxygen daily. Only when they come to change the oxygen tubing once a week, and she was not sure if the nurses dated the nasal cannula or not. Resident #26 said the nurse had not told her to stop increasing the oxygen setting on the concentrator or educated her on why she should not change the settings. During observation and interview on 01/02/24 at 12:43 p.m., LVN O said she observed the oxygen setting between 4 and 5 L. LVN O said Resident #26 had been changing the setting on the concentrator. All the nurses, the DON, and the ADON were aware of her changing the setting. LVN O said she could not remember if she notified Resident #26's physician or documented it. LVN O said she should have notified Resident #26's physician because the oxygen was increased above 2 liters. Which meant the physician's order was not followed, and Resident #26 could have had a negative respiratory outcome. LVN O said she had an in-service and skills check-off on how to work with a resident with oxygen. LVN O said the resident nasal cannula should be changed on Sunday and dated, proving it was changed. LVN O said it would prevent Resident #26 from using one cannula for an extended period. LVN said it also ensured the nasal cannula was not clogged up and it would deliver the oxygen appropriately. During an interview on 1/04/24 at 11:18 a.m., LVN J said the nasal cannula should be dated when changed weekly and PRN. She stated make sure the nasal cannula was patent, and there were no infection control issues. LVN J said Resident #26 does increase the setting of the oxygen on the concentrator, and the management is aware of it. LVN J said she told Resident #26 not to change the setting, and she could not remember if she notified the doctor about Resident #26 changing the setting. LNV J said if the set was increased above the physician's order, then the nurse should inform the physician and may get an order for a range if it would not cause any adverse outcome for Resident #26. During an interview on 01/04/23 at 2:19 p.m., the DON said if Resident #26's O2 was set on 5 L instead of 2, then the physician order was not followed, and Resident #26's physician should be notified. The DON said the nurses had told her not to touch the oxygen, and she had been educated about it, too. The DON said she would review the progress notes to see if the nurses notified the doctor that Resident #26 kept turning up her oxygen and the education documentation given to Resident #26. The DON said Resident #26 CO2 levels would be high, and it could affect her respiration. The DON said the NP would be the best person to talk to because she had worked with the two doctors who had taken care of Resident #26, and the nurses also reported to her about any Resident #26 issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 - Few	During an interview on 01/04/23 at 2:32 p.m., NP said none of the nurses had told her about Resident #26 adjusting her oxygen concentrator setting. The DON intervened and said the NP did not understand what the state surveyor said. The DON asked the NP if the nurses had told her about Resident #26 increasing her oxygen setting, and the NP replied none of the nurses had informed her about Resident #26 increasing the oxygen setting. NP said the nurses should check the setting on the oxygen when they made rounds according to the physician's order. During an interview on 01/04/23 at 3:50 p.m., ADON E said the nurse had told her Resident #26 does increase the oxygen setting, and the nurses educated Resident #26. ADON E said she was unsure if the nurses had notified the doctor. ADON E said if the oxygen setting was increased above the physician's order, the nurses should have reported to the physician because it could affect the resident negatively. During an interview on 01/05/23 at 1:30 p.m., the DON said she could not find any documentation that Resident #26's doctor was notified that Resident #26 was increasing her oxygen or any education documented. She had in-serviced the nurses about informing doctors if there were any issues with resident care. Record review of the facility policy on oxygen equipment revised 05/2007 read in part . it is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner . procedures . C. pre - filled humidifiers, when used are to bed dated and replaced every 10 days .tubing should be replaced every week . Requested oxygen administration policy and it was not provided upon exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16989 Based on observation, interview, and record review, the facility failed to ensure pain management provided for one resident (Resident #25) of five residents reviewed for pain was consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. -The facility did not have Resident #25's pain medication (Norco 7.5/325 mg) available. -Resident #25 missed 9 doses of Norco 7.5/325 mg over 5 days. -Resident #25 said her pain level was high during the time of the missed doses. The deficient practice caused Resident #25 to experience unnecessary pain. Findings included: Record review of the Admission Record (printed 01/05/2023) for Resident #25 revealed she was [AGE] years old and was originally admitted to the facility on [DATE]. Diagnoses included, but were not limited to, left sided hemiparesis (loss of use of the left arm and leg), history of healed fracture, and uterine cancer. Record review of the Care Plan dated 12/19/2023 revealed Resident #25 experienced acute and chronic pain in her left shoulder and from wounds on both legs. The 'Interventions' read, in part, .Administer analgesia [pain] medication as per orders. Monitor for side effects and effectiveness. Record review of the Physician Order dated 10/24/2023 revealed Resident #25 had an order for Norco 7.5/325 mg to be given two times daily from 10/26/2023 to 12/26/2023. Record review of the Physician Order dated 12/26/2023 revealed the Norco 7.5/325 mg was to be increased to three times daily. Record review of the December 2023 and January 2024 MAR revealed Resident #25 was not administered the following doses of Norco 7.5/325 mg: 12/29/2023 at 7:00 p.m. (1 dose) 12/30/2023 at 7:00 a.m. and 7:00 p.m. (2 doses) 12/31/2023 at 7:00 a.m., 3:00 p.m., and 7:00 p.m. (3 doses) 01/01/2024 at 7:00 a.m. and 3:00 p.m. (2 doses) 01/02/2024 at 7:00 a.m. (1 dose) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0697 Level of Harm - Actual harm Residents Affected - Some	In an interview with Resident #25 on 01/02/2024 at 10:43 a.m. revealed she said she had constant pain in her left hip. She said she has been out of the Norco 7.5/325 mg since yesterday and would need Tylenol. She said the nurse, LVN A, said she was out of the Norco 7.5/325 mg, and she told the nurse Tylenol was not effective. She reported her pain was currently 7 of 10, and constant. She said the pain level with Norco would be 3 or 4 of 10. She said it hurt more with movement. She said she had a left hip fracture but did not have a fall. She said she had reported pain and an x-ray confirmed a fracture. That occurred just before Christmas. She said she had not received any pain medication that morning but had not told anyone she was in pain. In an interview on 01/02/2024 at 11:13 a.m. RN B acknowledged Resident #25 was out of Norco 7.5/325 mg. He said the resident had a hip fracture, but also had osteoporosis and osteoarthritis. He said there was no Norco 7.5/325 mg in the emergency dispenser machine. He said he had called the pharmacy and they would be delivering the Norco 7.5/325 mg. He said he would administer the Norco 7.5/325 mg when it arrived. He said he had been unaware the resident was out of Norco 7.5/325 mg. In an interview on 1/2/2024 at 11:18 am RN B said he had notified the physician on Tuesday (12/26/2023) that Resident #25 had a three-day supply at that time. He said the physician changed the order to three times daily because the resident was having increased pain at night. He said he re-ordered the medication but did not work the next day. He said the nurse was responsible for ordering the narcotics. He said he was then unable to contact the physician or Nurse Practitioner. He said he had not reported it to the DON or Unit Manager. In an interview on 01/02/2024 at 11:34 a.m., MA C said she was assigned to administer Resident #25's Norco 7.5/325 mg, but it was not available. She said she notified the nurse. MA C had not worked during the previous four days. In an interview on 01/02/2024 at 2:13 p.m. Resident #1 said a nurse had administered her Norco 7.5/325 mg just before 2:00 p.m. She rated her pain level as between 5 and 6. In an interview on 01/02/2024 at 2:34 p.m. the DON said she was not aware of Resident #25's Norco 7.5/325 mg being unavailable. She said the nurse was responsible for ordering medications. She said if the medication was a controlled medication (Norco 7.5/325 is a controlled medication) the nurse was to call the physician for a prescription. She said there was a 'blocked out area' on the medication blister package to show when to reorder. She said the weekend nurse should have called the physician. Observation and interview on 01/03/2024 at 10:35 a.m. revealed Resident #25 was lying in her bed, awake. She said she had received her Norco 7.5/325 earlier that morning. She said her pain level was 4 or 5. She said her pain increased when the staff moved her. She said she was very relaxed. In a telephone interview on 01/03/2024 at 12:32 p.m. LVN M said she could not remember what day MA T told her she was giving the last medication of Norco 7.5/325 mg. She called NP B and she said she would tell Resident # 25's doctor to write a script for refill. LVN M said she texted Resident #25's doctor twice and NP B three times and none of them returned her text or called her. LVN M said Resident # 25 gets the pain medication three times a day. LVN M said the pain medication was in the emergency medication dispenser, but she needed to have an order to be able pull the medication. She said she did not call the medical director or the DON because she was under the impression that the doctor would call her back. LVN M said she failed to call the DON and it was her fault. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675743	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Phoenix Post-Acute	519 Ninth Ave N Texas City, TX 77590

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 0697 Level of Harm - Actual harm Residents Affected - Some	In a telephone interview on 01/03/2024 at 1:05 p.m. NP B said she did not recall getting a call from the nursing staff after the medication was increased on 12/26/23. NP B said the medication was increased to three times a day because of unrelieved pain. She said she told the nurses to call her before Resident #25's medication finished so she could tell the doctor to send in a script for refill. In a telephone interview on 01/03/2024 at 3:00 p.m. the physician said he did not receive a call from the facility until Monday (01/01/2024) at 10:30 a.m. He said the facility told him the resident was completely out of Norco 7.5/325 mg and she was in pain. He said the facility needed to give him 24 hours to return their call for medication refills.