

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605</p> <p>Based on interview and record review the facility failed to ensure personnel provided basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel for 1 of 5 residents (CR#1) reviewed for CPR.</p> <p>CNA A and CNA M failed to initiate life-saving measures (CPR) when CR#1 who had a full code status (all resuscitation procedures provided if their heart stops beating or they stop breathing) immediately when he was found unresponsive on [DATE] around 1:30 AM. EMS was called around 1:40 AM, arrived at 1:45 AM, and began CPR. CR#1 was transported to the hospital via emergency services, where he died on [DATE].</p> <p>An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 8:35p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.</p> <p>These failures placed residents at risk of experiencing worsening of condition, pain and death from possible delays in the initiation of an emergency response and improper implementation of CPR.</p> <p>Findings Included:</p> <p>Record review of facility census dated [DATE] revealed there were 74 residents.</p> <p>A review of Resident CR #1's face sheet, dated [DATE], revealed that he was a [AGE] year-old male admitted on [DATE], with a primary diagnosis of encephalopathy (a brain disease affecting cognitive function).</p> <p>Record review of Resident CR #1's care plan dated [DATE] and revised on [DATE] revealed the following care areas:</p> <p>CR#1 Full Code Status. Goal: Inform staff of code status, Full Code. Interventions: Monitor for decrease in change of condition</p> <p>Review of physician order, dated [DATE], revealed CR#1 was designated as full code status.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review</p> <p>Phone interview attempt with Nurse M on [DATE] at 3:00pm, but surveyor was unsuccessful.</p> <p>Phone interview attempt with CNA M on [DATE] at 3:30pm, but surveyor was unsuccessful.</p> <p>Phone interview attempt with CNA A on [DATE] at 3:45pm, but surveyor was unsuccessful.</p> <p>In a phone interview on [DATE] at 8:49am with CNA M, she said when she returned to work if a lunch break on [DATE] around 1:30 AM, CNA A came to the unit stating that CR #1 was off the premises on the ground and unresponsive. She said CNA A left CR #1 where she found him outside, to notify other staff and call 911 at approximately 1:40am. She said CNA A and CNA M returned to the location of the resident but did not initiate CPR because everything was happening so fast. CNA M stated she and CNA A did not have the AED or crash cart (a wheeled container carrying medicine and equipment for use in emergency resuscitations). She said that when she and CNA A arrived at the location where CR #1 was found, CR #1 was unresponsive with blood coming from his mouth. She said no one knew how long CR #1 had been unresponsive. She stated that EMS arrived about ,d+[DATE] minutes after CNA A called 911. She stated that CPR was initiated by EMS staff upon arrival. CNA M could not explain why CPR was not initiated prior to EMS arrival around 1:45am on [DATE]. She stated the facility was notified that CR #1 was pronounced deceased at the hospital at 2:11am on [DATE]. CNA M stated she was not suspended was still allowed to work following the incident. CNA M stated that she was not CPR certified, and she had not received CPR training while employed at the facility.</p> <p>Phone interview attempt with CNA A on [DATE] at 9:30am, but surveyor was unsuccessful.</p> <p>In interviews on [DATE] at various times with five CNAs, (CNA E, CNA C, CNA K, CNA D, and CNA T) they said they were unfamiliar with CPR response times and how to work an AED machine. All stated the facility had not provided CPR training in the last year, and it was not a requirement for employment.</p> <p>In an interview on [DATE] at 3:00pm, The DON stated she could not explain the facility's expectations of the staff implementation of a Code Blue (an emergency code used in a healthcare facility where a patient's life is at immediate risk due to cardiac arrest or respiratory failure). The DON stated staff should not leave a resident alone if found unresponsive. The DON stated that the facility had not provided CNA A and CAN M with CPR training. She stated that the facility did not require the CNAs and Nurses to be CPR certified. She stated that she was not aware of any CPR trainings or in-services provided recently. She stated that CR#1 was a full code status and CPR should have been initiated if CR#1 was unresponsive. The DON stated that a CODE Blue was not called. The DON did not explain who was responsible for ensuring that all staff were trained on code status and when to implement CPR. She did not explain how similar incidents would be prevented in the future. The DON stated that CNA M and CNA A had not been suspended or reprimanded following the incident.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 4:45pm, The Operations Manager stated he was notified of the incident at 5:30 a.m. on [DATE] by the Clinical Resources Nurse. CNA A left CR #1 on the sidewalk to call 911 from the facility. He stated that he was not aware of any staff training provided. The Operations Manager could not provide a timeline of the incident or identify the system failure. He did not explain how care staff would prevent future incidents from occurring. The Operations Manager stated he is responsible for managing the operations at the facility. He stated that the facility administrator was notified of the incident on [DATE] afternoon.</p> <p>Record review of CNA A and CNA M's employee files revealed no record of CPR training and certification for CNA A and CAN M.</p> <p>Record review of cardio-pulmonary resuscitation policy original date ,d+[DATE] with Revision/Review Date(s) ,d+[DATE] and ,d+[DATE] stated in part:</p> <p>It is the policy of this facility to provide basic life support (BLS), including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel in the absence of advance directives or a Do Not Resuscitate (DNR) order. Only staff members with current CPR certification for Healthcare Providers should perform the procedure. The facility will have staff certified in CPR available 24 hours/day to provide basic life support and CPR prior to the arrival of emergency medical services (EMS) personnel .</p> <p>Staff will maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes hands-on practice and in-person skills assessment .</p> <p>Record review of in-services revealed no documented CPR training provided in the one year look back period ([DATE] thru ,d+[DATE]/2024).</p> <p>Record review of CNA job description read in part: The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors. There was not referenced information related to CPR education requirement for CNA staff.</p> <p>An IJ was identified on [DATE] at 8:35p.m. The IJ template was provided to the Operations Leader and DON via email on [DATE] at 8:35p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on [DATE] at 2:38pm</p> <p>The Immediate Jeopardy findings were identified in the following area:</p> <p>F678 Cardio-Pulmonary Resuscitation:</p> <p>The facility failed to ensure that nursing staff provided CPR in accordance with professional standards, failed to provide on-going monitoring of a resident after a change in condition was identified and reported, failed to immediately and properly assess a resident after a change in condition was identified and reported, failed to document assessments performed after a change in condition was identified and reported, failed to immediately contact EMS when a resident was found unresponsive, and failed to thoroughly investigate an incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility failed to immediately initiate life-saving measures (CPR) when CR#1 when was found unresponsive on [DATE] around 1:30 AM. EMS was called around 1:40 AM, arrived at 1:45 AM, and EMS began CPR on CR#1. CR#1 was transported to the hospital via emergency services, where he was pronounced deceased on [DATE].</p> <p>Immediate Actions</p> <ol style="list-style-type: none"> 1. The Medical Director was notified of IJ on [DATE] at 8:46pm. 2. Review of licensed nursing staff personnel files was completed by Business Office Manager and Staffing Coordinator and validated by RN, Director of Nursing to ensure current licensed nurses held a current CPR card completed [DATE] and [DATE]. 3. CPR policy reviewed by DON, ED, Operations Manager, Clinical Resource, Clinical Market Leader, Medical Director and RT, Certified CPR Instructor [DATE]. No changes were made. 4. Education initiated with nursing staff [DATE] to provide basic life support, including CPR, and use of AED to any resident requiring such care, and alert EMS. Completion date [DATE]; training provided by RT, Certified CPR Instructor. Staff is trained prior to their next shift. Any staff unavailable will not be allowed to work until training is completed. 5. All nursing staff will complete CPR competency [return demonstration and BLS posttest] conducted by RT, Certified CPR Instructor, initiated [DATE]. Completion date [DATE]; training provided by RT, Certified CPR Instructor. Staff is trained prior to their next shift. Any staff unavailable will not be allowed to work until training is completed. 6. Education initiated with Therapy staff on [DATE] to provide basic life support, including CPR and the use of AED to any resident requiring such care and alert EMS. Completion date [DATE]; training provided by RT, Certified CPR Instructor. Staff is trained prior to their next shift. Any staff unavailable will not be allowed to work until training is completed. 7. All staff will be offered the opportunity to become CPR certified. [DATE] Nursing and Therapy staff are receiving CPR certification training; all other non-licensed staff will be offered CPR training. Completion date [DATE]; training provided by RT, Certified CPR Instructor. Staff is trained prior to their next shift. Any staff unavailable will not be allowed to work until training is completed. 8. This training and competencies - CPR training will be completed in-person with staff prior to the start of their next shift. <p>A member of management [ADONs or Staffing Coordinator] will be at the facility at each change of shift to ensure staff complete training prior to going to work on the floor.</p> <p>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 members will not be allowed to work unless they have received their training and knowledge check. [DATE]</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>9. To maintain compliance, HR will monitor CPR certification with DON oversight. [DATE] CPR certification will be maintained in a binder and reviewed at least monthly and/ or upon hire of licensed nursing/ therapy staff.</p> <p>Ad hoc QAPI meetings regarding items in the IJ template completed [DATE]. Attendees included the Medical Director, Clinical Resource, Operations Manager, DON, ADON, Clinical Resources, and Clinical Market Leader, and included the plan of removal items and interventions.</p> <p>The Operations Manager and DON were reeducated on CPR process by RN, Clinical Resource on [DATE].</p> <p>Monitoring of the plan of removal included the following:</p> <p>Record review of employee files who worked on [DATE] (6pm -6am), CNA M, CNA A, CNA E CNA C, Nurse T and LVN P revealed no record of staff being BLS certified, or CPR trained.</p> <p>Record review of education in-service training dated [DATE] and [DATE] revealed basic life support, including CPR competency and CPR in-services was provided to all staff scheduled on [DATE] and [DATE].</p> <p>Record review of QAPI sign-in sheet date [DATE] reflected MD participated via telephone, operations Leader, DON, Wound Care Nurse, Social Services, HR, MDS coordinator, Therapy Services, Clinical Resource Staff were in attendance.</p> <p>Record review of nursing staff personnel files was completed and revealed CPR competency as [DATE] all staff scheduled on [DATE] and [DATE].</p> <p>During the interview on [DATE] at 4:30am, Nurse T stated that she had worked at the facility for only a week and was not familiar with resident CR #1. Nurse T stated that she was the nurse assigned to CR#1 on [DATE] thur [DATE], at the time of te incident.She mentioned that she was unsure whether the resident had full code status or was an elopement risk. Throughout her shift, she only reviewed CR #1's MAR records and did not look at CR #1's care plan or orders regarding code status. She noted that this information could be found in the clinical record under physician orders, but she had not had the chance to review it. On the night of the prior to the incident ([DATE]), Nurse T recalled last seeing CR #1 at 11:00pm when she administered his medication. After this, CR #1 indicated he was going to bed, but Nurse T did not assist him in returning to his room or transferring from his wheelchair to his bed. She admitted she did not check on CR #1 between 11 PM and 1 AM and denied being asleep at any point during her 12-hour shift. Nurse T stated that she is currently CPR certified, but she was uncertain whether the facility had received documentation confirming this. During handoff report at the start of her shift, she was informed that CR #1 was independent and did not require assistance. At 1:00 AM on [DATE], CNA A informed her that CR #1 was missing from his room. Nurse T stated that she did not call an elopement code but could not explain why.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During the interview on [DATE] at 4:15am, CNA A reported that on the night prior to the incident ([DATE]), she saw CR #1 a local barbecue bar near the facility during her 15-minute break at approximately 10:45pm. She noted that CR #1 frequently left the facility independently and did not notify anyone of his whereabouts. At 1:30am on [DATE], she found CR #1 on the ground behind the facility near a barbecue bar, out of his wheelchair, bleeding from the mouth and unresponsive. She immediately returned to the facility called 911 and notified Nurse T and another CAN M who was the assigned staff to CR #1. She stated that Nurse T appeared to be sleeping at the time. CNA A and CNA M then returned to CR #1's location but did not initiate CPR, although she did not specify why it was not started. CNA A stated that she and CNA M did not take AED to the location of CR #1 upon returning. CNA A stated that she was not BLS certified, and the facility had not provided CPR training since she's been employed at the facility. She stated that EMS arrived approximately 10 minutes after being called. She stated that upon EMS arrival, EMS initiated CPR and transported CR #1 to the hospital where he was later pronounced dead.</p> <p>Interviews on [DATE] - [DATE] with staff on both shifts (6am - 6 pm) and (6pm to 6am) for CNAs and 6 a.m. -6 p.m. included the DON and Operations Leader, Nurse T, LVN B, and LVN J all on night (6pm to 6am) shift were able to verify in-services and to validate their understanding basic life support, including CPR, and use of AED. They were able to identify what was neglect and provide examples of some signs and symptoms of respiratory distress, the code for emergency (code blue) used. CNAs were able to explain they were in-serviced on calling the nurse when there is an emergency. LVN's and CNAs were able to explain the importance of calling a code blue promptly in response to emergencies; and how to check the code status in the clinical record to ensure they were able to conduct CPR. Staff was able to return demonstrations related to the process for providing CPR and using the AED. Staff was able to verbalize and understanding of the facility's CPR policy related to CPR implementation.</p> <p>The Operations Leader was informed the Immediate Jeopardy was removed on [DATE] at 10:00 am. The facility remained out of compliance at a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605</p> <p>Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 5 residents (CR #1) reviewed for supervision.</p> <p>The facility failed to provide sufficient supervision to CR#1 on [DATE] at 1:30am, when he was found unresponsive behind the facility, with blood coming from his mouth. CR#1 was transported to the hospital via emergency services, where he was pronounced deceased on [DATE].</p> <p>Multiple staff working the night shift (CNA E, CNA A, CNA M, CNA C and Nurse T), were unaware CR#1 was missing from the facility and an elopement code was not initiated.</p> <p>There was not an effective system in place to track residents entering and exiting the building.</p> <p>An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 7:45p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.</p> <p>These failures could result in residents not receiving appropriate supervision leading to elopement, injuries, hospitalization , or death.</p> <p>Findings included:</p> <p>Record Review of CR #1's face sheet, dated [DATE] revealed that he was a [AGE] year-old male admitted on [DATE], with a primary diagnosis of encephalopathy (a brain disease affecting cognitive function).</p> <p>Record Review of CR #1's MDS assessment dated [DATE] indicated that CR #1 had a BIMS score of 7 out of 15, reflecting severely impaired cognition. He had no behaviors, including wandering, and required substantial/maximal assistance with transfers from bed to chair.</p> <p>Record review of the elopement risk assessment for CR #1, dated [DATE], reflected the elopement risk assessment failed to reveal that CR #1 was a low risk for elopement.</p> <p>The comprehensive care plan initiated on [DATE] did not include a care plan for impaired cognition or address wandering or elopement.</p> <p>Record review</p> <p>Observation on [DATE], at 11:45am revealed upon the surveyor's arrival, no receptionist or staff member was present at the desk to monitor exit-seeking residents at the front door.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On [DATE] starting at 12:55pm, in phone Interviews with two-night CNAs (CNA E and CNA C), they stated that they did not see CR #1 at all during their shift on [DATE] and [DATE] and did not know CR #1 was missing. They stated they would usually see CR #1 through their shift, but lately he had not been his usual self. Both stated they were in- serviced on elopement process on [DATE] following the incident. Neither could explain why an elopement code was not called on [DATE] in the morning.</p> <p>Observation on [DATE] starting at 12:30pm, revealed residents (later identified as Resident #2 and Resident #3) exiting without signing out or being accommodated by staff. It was unclear if residents were leaving to smoke or leaving to go out on pass.</p> <p>On [DATE] at 12:55pm, in an interview with receptionist, she stated that there was no desk coverage after 10:00 p.m., and all residents should be in after the last smoke break. The receptionist stated staff (activity director or receptionist) typically accompanied residents while in the smoking area, but there was no clear way to distinguish residents leaving for smoke breaks from those leaving for other reasons. The receptionist stated that there is no coverage at the receptionist desk when accompanying residents while they are smoking.</p> <p>In interviews on [DATE] starting at 1:10pm, Three CNAs (CNA K, CNA D and CNA T) and two nurses (LVN A and RN L) revealed staff had been recently in-serviced on resident sign-in/sign-out procedures. They conducted resident rounds every two hours and were required to call a Code 20 for elopements. However, staff were unfamiliar with the Resident Roster list, which identified residents needing assistance when exiting, and could not explain who was responsible for escorting these residents.</p> <p>In an interview on [DATE] at 2:00pm, The Operations Leader stated he was notified of the incident at 5:30 a. m. on [DATE] by the Clinical Resources Nurse. He reported that CNA A found CR #1 unresponsive on a nearby sidewalk at 1:30 a.m. CNA A, who was not assigned to Resident #1, discovered him while returning from lunch. She left him on the sidewalk to call 911 from the facility. Staff were unaware that CR #1 had left, as he had not signed out. He stated that CR #1 had a history of leaving without signing out. The Operations Leader stated nothing had been done to address CR #1 not signing out. The Operations Leader stated that the residents are responsible to sign-in/sign-out. The Operations Leader was not able to identify who was responsible for reviewing the sign in and out sheets. The Operations Leader was aware that there is no receptionist at the front desk after 10:00pm. He stated that he was not aware of any staff training provided to address what to do after 10:00pm when the receptionist leaves. The administrator stated he reviewed video surveillance on [DATE], which showed CR #1 leaving at 10:38pm on [DATE], but there was no footage of him returning. The administrator could not provide a timeline of the incident or identify the system failure. He stated the facility had implemented a Resident Roster list that will remain at the front desk with the receptionist, which identified residents needing assistance when exiting, but could not explain who was responsible for escorting these residents. He could not explain how care staff would be made of aware of the list and how the list prevented future incidents form occurring.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on [DATE] at 4:00pm, The DON said she was informed of the incident at 1:47 a.m. on [DATE]. She stated that Nurse T had last seen CR #1 at 11:00pm on [DATE] during medication rounds, and CR #1 had said he was going to bed. The DON stated that Nurse T did not follow up to ensure CR #1 was in bed as she was new at the facility and was not familiar with CR #1. The DON stated that she was aware that CR #1 was not compliant with signing in and out. The DON did not reveal who was responsible for checking to ensure that the sign in and out sheet were being completed daily. The DON stated nothing had been done to address CR #1 not signing out. The DON was aware that there was no receptionist at the front desk after 10:00pm daily. She stated she had not provided staff trainings to address what to do after 10:00pm when the receptionist leaves. The DON stated there was no policy specifying how frequently staff should round on residents. She stated another resident previously eloped in [DATE], and the facility implemented a sign-out form, but no additional measures were taken. She stated the form was implemented by in servicing the residents and staff that residents are to sign out when leaving the facility on a leave pass. She could not explain how the implementation of the acknowledgment form had been reviewed for its effectiveness in keeping the residents safe and preventing future elopements. She could not explain the facility's expectations of the staff in the identified implementation. The DON stated that residents have the right to leave the facility when they like, but she could not identify the facility's role in ensuring the safety and account of residents leaving or returning. The DON could not explain how the facility ensured the daily accurate census if residents leave without signing out. The DON said an elopement code was not initiated during the incident as staff were unaware CR #1 had gone missing. The DON stated staff was trained on elopement code and process on [DATE], following the incident. She also noted that while a Resident Roster was created based on cognitive levels, staff had not been trained on its use. She stated the facility had implemented a Resident Roster list that will remain at the front desk with the receptionist, which identified residents needing assistance when exiting, but could not explain who was responsible for escorting these residents. She could not explain how care staff would be made aware of the list and how the list prevented future incidents from occurring.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 8:49am, in an interview with CNA M, who was assigned to CR #1 the night of the incident, CNA M stated she had last seen CR #1 around 6:00pm on [DATE], when she provided his dinner tray to him. She stated that the shifts started at 2:00pm on [DATE] and the resident was lying in bed at that time. She stated this was not unusual as the resident seemed to be depressed for the past two months, after losing his roommate. She stated that nursing staff was aware that he was not his usual self, but she was unaware if anything had been done to address the decline. She stated that at 12:30am on [DATE] (while on her lunch break) she noticed that CR #1's room light was on. She stated that that she had not check on CR #1 from 6:00pm on [DATE] and 12:30pm on [DATE] because CR #1 was independent and could communicate his needs. She stated that she noticed that CR #1 was not in his room, and she informed Nurse T. She stated that Nurse T stated that she had last seen him at 10:45pm when she gave him his nightly medication and he stated he was going to bed. CNA M stated the staff did not assist him in transferring from his chair to bed or ensure that CR #1 was in bed. CNA M stated she was not aware that CR #1 required assistance to bed. She also stated that Nurse T as new and was not familiar with CR #1. She stated that an elopement code was not called as she recalled everything happening so fast. She stated another staff, CNA A, who was not assigned to CR #1 came to the unit at 1:30am on [DATE] stating that CR #1 was off the premises on the ground and unresponsive. CNA A left CR #1 and called 911. CNA A and CNA M returned to the location of the resident. CNA M stated it is unknown how long CR #1 had been unresponsive. She stated the facility for notified that CR #1 was pronounced deceased at the hospital at 2:11am on [DATE]. CNA M stated the resident left the facility all the time without signing in and out and the facility administration was aware of it. She stated there is no keypad code required to exit the build afterhours, but a keypad code is required to re-enter. She stated that resident have the key code (a number code required to be entered in a keypad before entered the facility) and there is no system to account for residents. She stated there is no receptionist after the last scheduled smoke break at 10:00pm each day. She stated that CR #1 was a smoker. She stated that even when there is a receptionist there is no system to account for the residents. She stated that the care staff and receptionist did not communicate when a resident was leaving. She stated if the resident did not sign out there is no way for staff to know the resident whereabouts. CNA M stated the facility system is not designed to keep the residents safe.</p> <p>During the interview on [DATE] at 4:30am, Nurse T stated that she had worked at the facility for only a week and was not familiar with resident CR #1. Nurse T stated that she was the nurse assigned to CR#1 on [DATE] thur [DATE], at the time of te incident. She mentioned that she was unsure whether the resident had full code status or was an elopement risk. Throughout her shift, she only reviewed CR #1's MAR records and did not look at CR #1's care plan or orders regarding code status. She noted that this information could be found in the clinical record under physician orders, but she had not had the chance to review it. On the night of the prior to the incident ([DATE]), Nurse T recalled last seeing CR #1 at 11:00pm when she administered his medication. After this, CR #1 indicated he was going to bed, but Nurse T did not assist him in returning to his room or transferring from his wheelchair to his bed. She admitted she did not check on CR #1 between 11 PM and 1 AM and denied being asleep at any point during her 12-hour shift. Nurse T stated that she is currently CPR certified, but she was uncertain whether the facility had received documentation confirming this. During handoff report at the start of her shift, she was informed that CR #1 was independent and did not require assistance. At 1:00 AM on [DATE], CNA A informed her that CR #1 was missing from his room. Nurse T stated that she did not call an elopement code but could not explain why.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During the interview on [DATE] at 4:15am, CNA A reported that on the night prior to the incident ([DATE]), she saw CR #1 a local barbecue bar near the facility during her 15-minute break at approximately 10:45pm. She noted that CR #1 frequently left the facility independently and did not notify anyone of his whereabouts. At 1:30am on [DATE], she found CR #1 on the ground behind the facility near a barbecue bar, out of his wheelchair, bleeding from the mouth and unresponsive. She immediately returned to the facility called 911 and notified Nurse T and another CAN M who was the assigned staff to CR #1. She stated that Nurse T appeared to be sleeping at the time. CNA A and CNA M then returned to CR #1's location but did not initiate CPR, although she did not specify why it was not started. CNA A stated that she and CNA M did not take AED to the location of CR #1 upon returning. CNA A stated that she was not BLS certified, and the facility had not provided CPR training since she's been employed at the facility. She stated that EMS arrived approximately 10 minutes after being called. She stated that upon EMS arrival, EMS initiated CPR and transported CR #1 to the hospital where he was later pronounced dead.</p> <p>Record review of review of CR #1 the sign out sheet revealed that there was no record of CR #1 signing out on [DATE] and [DATE].</p> <p>Record review of nursing noted for [DATE] and [DATE] revealed no documentation of the timeline of the incident.</p> <p>An IJ was identified on [DATE] at 7:45pm The IJ template was provided to the Operations Leader and DON via email on [DATE] at 7:45pm.</p> <p>The facility's Plan of Removal was accepted on [DATE] at 3:46pm, and included the following interventions:</p> <p>The Immediate Jeopardy findings were identified in the following area:</p> <p>F 689 Quality of Care</p> <p>The facility failed to ensure adequate supervision to prevent accidents for 1 of 5 residents (CR#1) reviewed for supervision.</p> <p>The facility failed to provide sufficient supervision to CR#1 on [DATE] at 1:30am, when he was found unresponsive behind the facility, with blood coming from his mouth. CR#1 was transported to the hospital via emergency services, where he was pronounced deceased on [DATE].</p> <p>Immediate Actions</p> <ol style="list-style-type: none"> 1. The Medical Director was notified of IJ on [DATE] at 8:06 PM. 2. Education initiated with all staff on [DATE] on Abuse: Prevention of and Prohibition Against to include Neglect with a post test. Reeducation initiated [DATE]. Completion date [DATE]. Training provided by DON/designee. 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. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. The Out-on-Pass policy was reviewed by the IDT and revised. The three strike rule will be implemented in cases of repeated non-compliance to this policy. Upon the third strike, the Business Office and Administrator may choose to initiate the process of issuing a 30-day discharge notice to the resident.</p> <p>An ad hoc QAPI was held. [DATE]. Policy was approved in the Ad hoc QAPI.</p> <p>4. Education initiated with all staff on [DATE] on Out-on-Pass Policy and residents will be required to sign out to go out on pass; with a census of residents that identifies which residents are independent and which require supervision when out on pass. 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. [DATE] Training was conducted by DON/ designee and Staffing Coordinator.</p> <p>5. .d+[DATE] receptionist staffing initiated on [DATE]. Reeducation on receptionist protocol initiated on [DATE], including policy that if the receptionist needs to step away, another staff member will relieve the receptionist. 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. [DATE] Training provided by DON/ designee; Operations Manager and Staffing Coordinator. Sister facility DONs/ ED or Ops Manager will be scheduled to completed knowledge checks daily x 2 weeks, then weekly x 2 weeks to monitor effectiveness. DON/ designee will monitor effectiveness weekly in Systems Review.</p> <p>6. Social Services and Medical Records will ensure that the Out-on-Pass acknowledgement is signed by residents, this will include a three strike rule for compliance. [DATE]. Social Services will be responsible for reviewing with the effectiveness of this protocol with oversight from the Operations Manager. This will be reviewed weekly during the Systems Review by the DON/ ADONs/ Social Services.</p> <p>7. Education initiated with all staff on [DATE] on elopement policy and identifying residents at risk for elopement and when to initiate and elopement response. 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. The training is being provided by the DON/ ADON/ Staffing Coordinator with a knowledge check. Elopement drills will be conducted at a minimum of monthly by the Maintenance Director and reviewed by the DON, effectiveness will be reviewed at the time of the drill.</p> <p>8. Elopement assessments of all residents were reviewed to identify which residents are elopement risks on [DATE]. Binders were placed at each nurse station and the receptionist desk for identification purposes on [DATE]. Residents who scored high for elopement risk, currently reside in the secured units (2nd floor); no residents on 3rd floor were identified as at risk for elopement.</p> <p>9. Elopement drills were held twice a day from [DATE]-14, and will continue three times a week x 4 weeks, then weekly x 4 weeksXXX[DATE] The DON/ ADONs/ Staffing Coordinator conducted the drills. An elopement drill form will be completed for each drill.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Elopement policy was reviewed by DON, Operations Manager, Clinical Resource, Clinical Market Leader and Medical Director [DATE]. No changes were made.</p> <p>Education initiated with all nursing staff on [DATE] regarding making rounds routinely. Approximately every 2 hours, dependent on resident needs and or preference. 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. [DATE] Training provided by DON/ ADONs/ Staffing Coordinator.</p> <p>Charge nurses will perform census count every shift. [DATE] The shift census will be tracked utilizing a census sheet with the charge nurse signing off, indicating all residents are accounted for. Charge Nurses will report absent/ missing residents at the time of the census check to the DON/designee. ADONs/ designee will be responsible for collecting daily, when on duty and reviewing.</p> <p>These trainings 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.</p> <p>Ad hoc meetings regarding items in the IJ template completed [DATE]. Attendees included the Medical Director, Operations Manager, DON, ADONs, Clinical Resources, and Clinical Market Leader, and included the plan of removal items and interventions. The ad hoc QAPI was acknowledged and the plan with the interventions were agreed upon.</p> <p>Monitoring:</p> <p>Observations on [DATE] at 12:30 pm and 2:30pm and on [DATE] at 4:00am and 12:00pm - 2:30pm revealed someone sat in the receptionist area, and coverage was provided when the receptionist was gone on break.</p> <p>Observations on [DATE] stating at 4:00am thru 6:00am and 8:00am thru 10:00am revealed were completing frequent rounding on by checking on the residents there in the units.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER The Phoenix Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interviews on [DATE] - [DATE] with staff on both shifts (6am - 6 pm) and (6pm to 6am) for CNAs and 6 a.m. -6 p.m. included the DON and Operations Leader, Nurse T, LVN B, and LVN J all on night (6pm to 6am) shift and the receptionist were able to verify in-services elopement drills were provided. Nursing staff were able to appropriately define elopement risk, identify the location of the resident elopement book, provided the procedure for a resident found trying to leave the facility without supervision (report to the charge nurse). The Receptionists said they were to let nursing staff or administrative staff, if available, know when they were going on break. All the receptionists knew to check the census sheet who was able to verify resident who were able to leave out on pass. The receptionist said she was to let nursing staff know she was going on break so someone could relieve her to cover the front desk while on break. All interviewed nursing staff stated that they were aware that 24-hour coverage would be maintained at the receptionist desk. CNA stated that they were made aware that they would rotate the responsibility of relieving the receptionist for bathroom and lunch breaks. Nursing and CNA staff stated they were in-serviced on rounding at least every 2 hours.</p> <p>Interview on [DATE] at 10:30am with Social Services Staff, she stated that she had been in-serviced on the policy for residents going out on pass and three-strike rule for noncompliance. She stated that if residents were non-compliant with the going out on pass policy, a IDT meeting would be held to determine the next best step for the resident.</p> <p>Record review Reeducation on receptionist protocol initiated on [DATE], including policy.</p> <p>Record reviews revealed an Elopement Risk binder was located at the nursing station with the face sheets of all current residents and the elopement risk assessments for each resident.</p> <p>Record reviews of the charts were completed for Resident #s 2, 3, 4 and 5 and reflected elopement assessments. Resident care plans included their elopement status.</p> <p>Record review of training sign in sheet dated [DATE] thru [DATE] revealed that elopement in-services were completed with nursing staff who were scheduled to work on [DATE] thru [DATE].</p> <p>Record review of census counts was verified on [DATE] and revealed that a census count was completed and sign off on by the charge nurse.</p> <p>Record review of trainings and in-services revealed that elopement drills were completed on [DATE] and [DATE] with nursing staff scheduled to work on [DATE] and [DATE].</p> <p>Record review of trainings and in-services dated [DATE] revealed that social service staff had been in-serviced on the resident going out on pass and three strike rule for resident who were noncompliant.</p> <p>The Operations Leader was informed the Immediate Jeopardy was removed on [DATE] at 10:00 am The facility remained out of compliance with a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.</p>		