

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 03/12/2025
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 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48315</p> <p>Based on interview, and record review the facility failed to ensure the resident's had the right to have reasonable access to the use of telephone, including TTY and TDD services, and a place in the facility where calls could be made without being overheard for 1 of 3 (Resident #1) residents reviewed for telephone use.</p> <p>The facility failed to provide a place for Resident #12 to make telephone calls without being overheard.</p> <p>This failure could place residents at risk of conversations being overheard and privacy right's not being respected and could result in a decline in resident's psychosocial well-being and quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #12, dated 01/14/2021, reflected a [AGE] year-old female who was admitted to the facility on [DATE].</p> <p>Record review of Resident #12's History and Physical, dated 01/28/23, reflected a diagnosis which included depression (a common mental health condition characterized by persistent low mood, loss of interest or pleasure in activities, and other symptoms that interfere with daily functioning.)</p> <p>Record review of Resident #12's quarterly MDS , dated 10/23/24, reflected a BIMS of 15, which indicated the resident was cognitively intact.</p> <p>During interview with Resident #12 on 03/11/2025 at 10:30AM revealed Resident #12 said she called friends or family on the phone at the nursing station she was told that was the only place to make a telephone call or if you had a cell phone. Resident #12 said the facility did not have cordless phones to use and most of the resident's conversations were heard by the nurses or anyone walking by. Resident #12 said the residents only got 15 minutes due to the nursing staff needing to use the phone. Resident #1 said she had not been offered any other phone to use in private. Resident #12 said he knew how to use the phone; however staff would call the number for her. Resident #12 said she did not feel secure in her conversations and speaking in an open area, and she knew the nurse could hear her conversation. Resident #12 said it made her feel like she did not have any privacy.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview with the DON on 03/11/2025 at 11:20 AM, the DON said the nurse's station was the only area for residents to use the phone. Many of the alert residents had their own personal cell phones. The DON said unfortunately the facility did not have an area for the residents to use for privacy.</p> <p>During interview with the facility Administrator on 03/11/2025 at 12:00 PM, the Administrator said the residents were able to use the phone at the nurse's station or at the receptionist desk if need be. The Administrator stated he had a phone by his office, or the residents could use the phone in the Administrator's office, if needed, but as of now the facility did not have designated area for the resident to use and the facility was currently working on designating the physician office into the resident's phone area. The Administrator said the facility did not have a policy on resident phone use and privacy.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036</p> <p>Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 of 4 medication carts observed.</p> <p>The facility failed to dispose of Levothyroxine 88 mcg blister pack with expiration date of 1/31/25 for Resident #55 from 2 [NAME] nurse medication cart on 3/11/25.</p> <p>This failure could place residents at risk of receiving expired medications or inaccurate dosage of medication which could lead to resident not receiving full therapeutic benefits of a medication or possible side effects.</p> <p>Findings include:</p> <p>Record review of Resident #55's face sheet, dated 3/11/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #55 had diagnoses which included Other Alzheimer's Disease (progressive brain disorder that destroys memory and thinking skills), Unspecified Dementia (group of symptoms affecting memory, thinking and social abilities) with Mood Disturbance, Schizoaffective Disorder/Bipolar Type (Disorder with abnormal thought processes and an unstable mood), and Hypothyroidism (Underactive Thyroid).</p> <p>Record review of Resident's #55's quarterly MDS, dated [DATE], revealed a BIMS score of 12, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #55's Order Audit Report, dated 3/12/25, revealed Levothyroxine Sodium Oral Tablet Give 88 mcg by mouth in the morning was discontinued on 10/29/2024 at 7:59 p.m.</p> <p>Record review of Resident #55's Order Audit Report, dated 3/11/25, revealed Synthroid Oral Tablet 100 mcg (Levothyroxine Sodium) Give 1 tablet by mouth in the morning was created 10/29/24 at 7:48 p.m. and was an active order.</p> <p>Record review of Doctor's Progress Note, dated 10/28/24, revealed start levothyroxine 100 mcg p.o. daily, discontinue levothyroxine 88 mcg p.o. daily.</p> <p>Record review of Resident #55's Location of Administration Report, for October 2024 printed on 3/12/25, revealed Resident #55 was last administered Levothyroxine Sodium Oral Tablet 88 mcg on 10/29/24 and was administered Synthroid Oral Tablet 100 mcg (Levothyroxine Sodium) on 10/31/24.</p> <p>Record review of Resident #55's Location of Administration Report for March 2025, printed on 3/11/25, revealed Synthroid Oral Tablet 100 mcg (Levothyroxine Sodium) was administered from 3/1/25 through 3/11/25.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #55's Care Plan, printed 3/11/25, revealed has hypothyroidism and interventions included: Give thyroid replacement therapy as ordered.</p> <p>Observation on 3/11/25 at 9:22 a.m. of 2 [NAME] nurse medication cart revealed Levothyroxine 88 mcg blister pack with expiration date of 1/31/25 for Resident #55 was found on 2 [NAME] nurse medication cart. LVN A immediately removed the Levothyroxine 88 mcg blister pack from the 2 [NAME] nurse medication cart.</p> <p>During interview on 3/11/25 at 9:22 a.m., LVN A said Levothyroxine 88 mcg blister pack for Resident #55 was expired. LVN A said she went through the medication cart weekly to make sure there were no expired medications, and the Levothyroxine 88 mcg blister pack must have gotten missed.</p> <p>During interview on 3/11/25 at 2:11 p.m., ADON A said when a medication is discontinued the nurse or CMA should take the medication off the cart. ADON A said the RN supervisor (RN A) on the weekend did medication cart audits once a month.</p> <p>During interview on 3/11/25 at 2:13 p.m., ADON B said cart checks for expired medications should be done weekly. ADON B said she tried to look at the medication carts monthly. ADON B said the weekend supervisor (RN A) checked the medication carts this past weekend. ADON B said the CMAs and nurses were ultimately responsible for expired medications on their carts.</p> <p>Attempted interview with RN A on 3/11/25 at 3:00 p.m. was unsuccessful.</p> <p>Attempted interview with RN A on 3/11/25 at 5:20 p.m. the State Surveyor sent RN A a text message after receiving voicemail from RN A to coordinate contact.</p> <p>During interview on 3/12/25 at 8:59 a.m., LVN B said she checked the nurse medication cart for expired medication on Saturdays which included blister packs.</p> <p>During interview on 3/12/25 at 9:05 a.m., MA A said she checked the medication carts once a week for expired medications which included blister packs.</p> <p>During interview on 3/12/25 at 9:08 a.m., the Pharmacist said he performed medication cart checks biweekly. Medication cart checks included checking for expired medications which included blister packs. The Pharmacist said Levothyroxine may have been left on a medication cart in case they were adjusting the resident's dose.</p> <p>During interview on 3/12/25 at 10:15 a.m., Resident #55 said there was not anything wrong with him when he was asked if he took a thyroid medication. Resident #55 said the facility would try to give him four or five pills, but he refused to take them.</p> <p>During interview on 3/12/25 at 10:23 a.m., MA B said she usually checked her medication cart for expired medications two times a week on Tuesdays and Thursdays which included blister packs. MA B said the nurse would also check the medication aide medication cart, but she was not sure how often.</p> <p>During interview on 3/12/25 at 10:25 a.m., LVN C said she checked the nurse and medication aide medication carts once a week which included blister packs usually on night shift.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 3/12/25 at 10:27 a.m., LVN D said she checked the nurse medication cart every other weekend for expired medications. LVN D said she would check the top drawer of the medication aide medication cart for medications like eye drops. The top drawer of the medication aide medication cart also included the over -the-counter medications.</p> <p>During interview on 3/12/25 at 2:30 p.m., Clinical Resources (who was acting as DON) said the nurses and CMAs were to check the medication carts they were assigned weekly and as needed for expired medications. Clinical Resources also said the pharmacy performed monthly checks to medication carts for expired medications.</p> <p>Record review of the facility's policy Storage of Medications with revision, dated April 2007, revealed The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.</p>		