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	05/14/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary medication and potential overmedication in accordance with professional standards of practice for 1 of 12 (Resident #79) residents reviewed for pharmacy services.The facility failed to ensure Resident #79 was free from duplicate medication therapy as evidenced by Resident #79's two active orders of the same medication with two different dosages. This failure could place residents at risk for adverse drug events. Record review of Resident #79's face sheet dated 5/14/2026 revealed a [AGE] year old male admitted to the facility originally on 7/14/2023 and readmitted on [DATE] with diagnoses which included Tourette's Disorder (a nervous system condition that causes people to make uncontrollable, repetitive movements or sounds, known as tics), Cognitive Communication Deficit (a condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes, rather than a primary problem with language or speech), and Ataxic Gait (unsteady, wobbly, or staggering walking pattern caused by poor muscle coordination and lack of balance).Record review of Resident #79's most recent MDS assessment completed on 4/22/2026 revealed Resident #79 had a BIMS score of 15 which indicated intact cognition. Record review of Resident #79's Order Summary Report dated 5/13/2026 included the following;1. Baclofen Oral Tablet 10 mg - Give 1 tablet by mouth three times a day for pain with an order start date of 1/30/2026 and no end date.2. Baclofen Orab Tablet 15 mg- Give 1 tablet by mouth three times a day for muscle relaxation with an order start date of 5/12/2026 and no end date. Record review of Resident #79's Medication Administration Record dated 5/13/2026 revealed Resident #79 received Baclofen 10 mg on 5/12/2026 at 8:00 a, m., 2:00 p.m., and 8:00 p.m. Resident #79 also received Baclofen 15 mg on 5/12/2026 at 11:00 a.m., and 3:00 p.m. Record review of Resident #79's Medication Administration Record dated 5/13/2026 revealed Resident #79 received Baclofen 10 mg on 5/13/2026 at 8:00 a.m. and 2:00 p.m. Resident #79 also received Baclofen 15 mg on 5/13/2026 at 7:00 a.m., 11:00 a.m. During an observation on 5/13/2026 at 2:10 p.m., CMA B was observed as she prepared to administer medication to Resident #79. CMA B placed Baclofen 15 mg in a medication administration cup, proceeded to enter Resident 79's room, and was stopped by Surveyor and asked to return to hallway. During an interview on 5/13/2026 at 2:11 pm, CMA B stated she had worked at the facility for two years. CMA B stated she did not know the last time Resident #79 received Baclofen. CMA B stated she did not usually look at previous doses of when a medication was given and only looked at medication times. CMA B returned to her medication cart and reviewed Resident #79's Baclofen medication orders. CMA B stated she could see Resident #79 had two orders for Baclofen with two different dosages. CMA B stated that that she would clarify the Baclofen order with the nurse. CMA B stated the risk to the residents who received excessive doses of Baclofen was overly medicated . CMA B was unable to elaborate on what overly medicated meant.During an interview on 5/13/2026 at 2:16 p.m., LVN C stated that she worked at the facility for five years. LVN C stated CMA B would not be able to view previous doses of a medication that had been administered to a resident. LVN C stated that whoever placed the order of Baclofen 15 mg three times a day in Resident #79's record should have reviewed the previous order of Baclofen 10 mg three times a day (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
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and clarified the order with the provider. LVN C stated that the risks of giving extra doses of Baclofen to a resident included oversedation and falls.During an interview on 5/14/2026 at 3:12 p.m., the DON stated that PA entered the orders for her residents which included Resident #79. The DON stated she was the only provider who entered and discontinued her own orders in the resident's electronic record. The DON stated that usually orders were received verbally or were written down. The nurses entered the orders in the electronic record and received clarification if needed. The DON stated that the PA did not discontinue Baclofen 10 mg and should have. The DON stated the risk to Resident #79 was none since the maximum dosage was 80 mg daily. During an interview on 5/14/2026, the PA stated she had worked at the facility for seven months. The PA stated that Resident #79 was under her care. The PA stated she thought she had discontinued the Baclofen 10 mg three times a day order after she entered the new order for Baclofen 15 mg three times a day. The PA stated that apparently, she had not discontinued it. The PA stated she would normally go over the new medication orders and medication administration record before she submitted her orders and notes. The PA stated that the risk to Resident #79 for receiving duplicate doses of Baclofen was nothing urgent. The PA stated the risks were nothing bad system wise, as the dosage had not hit the maximum daily dosage, but could have caused increased sedation. Record review of the facility's policy titled Identifying and Managing Medication Errors and Adverse Consequences dated 2001 and revised in April 2007, read in part Staff and practitioner shall strive to minimize adverse consequences by following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication.