

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/27/2025
NAME OF PROVIDER OR SUPPLIER Deerbrook Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9250 Humble-Westfield Rd Humble, TX 77338	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24-hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (which included the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with State Law through established procedures for 1 of 7 residents (CR #1) reviewed for abuse and neglect. The facility failed to report to HHSC when CR #1 was found to have eloped from the facility on 3/21/25. This failure to report could place the residents at risk for neglect. Findings included: Record review of CR #1's face sheet dated 10/22/25 revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on 6/27/25 to another nursing facility. His diagnosis included dementia, mood disorder, anxiety, and bilateral hearing loss. Record review of CR #1's Elopement Risk assessment dated [DATE] revealed he was not at risk for elopement/wandering. Record review of CR #1's admission MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15 which indicated moderate cognitive impairment. He was independent with ADLs and there was no wandering behavior exhibited. Record review of CR #1's care plan revealed he had impaired cognitive function/impaired thought processes related to dementia. Interventions were to discuss concerns about confusion and disease process and keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion, initiated 2/26/25. Record review of CR #1's Complete Evaluation/Psychosocial dated 2/26/25 written by the Psychologist indicated CR #1 had moderate cognitive loss. On exam he was cooperative and attentive with no gross behavioral abnormalities. The therapy content/clinical summary read in part, .he was open about memory, secondary to dementia. and depression about my (family member) left me recently, after she put me here. he talked about last few months at home being challenging with him wandering out of house and getting very frustrated with his cognitive challenges. Record review of CR #1's Physician/NP/PA/H&P progress note dated 3/6/25 written by NP V indicated the patient had severe deficits in cognition and memory. Record review of CR #1's behavioral complete evaluation dated 3/10/25 written by the Psychiatric Mental Health NP read in part, .Patient carries a diagnosis of dementia, anxiety and depression. Patient was seen in the common area ambulating. He reports my (family member) brought me here since I am not safe at home. Dementia: patient exhibits symptoms of dementia. Symptoms are observable. Onset: (CR #1's) symptoms were first noticed a few years ago. The first symptoms reported were: . got lost in familiar settings and began losing things. Course of illness: (CR #1's) symptoms have been slowly progressive. Recent symptoms suggest that cognitive deficits are moderately severe. His symptoms are chronically present during the whole day. (CR #1) exhibits the following moderate symptoms: He confabulates stories or details to hide defects in memory; restless behaviors like pacing. has increased; He cannot organize thoughts or follow logical explanations; poor judgment is creating safety issues when left alone. (CR #1's) memory problems are prominent. he forgets more frequently than previously. He loses track of what is happening . Exam: . His thoughts are loosely associated in a circumstantial way. Psychotic or borderline psychotic symptoms seem to be present. Disorganized behavior has been observed. Bizarre behavior has been observed. Delusional ideas are expressed. Paranoid ideas are expressed. moderate cognitive loss is present. this patient is not aware of current events. There is difficulty thinking abstractly. He does not correctly give the current date and time. He correctly gives his current location. He correctly gives his name. He is not aware of his current situation. Diffuse memory loss for recent and remote events is present. Periods of confusion with disorientation and memory problems are in evidence. (CR #1) presents as alert. Insight into problems appears to be poor. Judgment appears to be poor. There are signs of anxiety. A short attention span is evident. He is easily distracted. Record review of CR #1's progress note dated 3/11/25 written by NP Q revealed he was confused but was able to provide some insight on current complaints. Record review of an undated soft file document entitled CR #1 Investigation of events - leaving facility unattended provided by the facility on 10/23/25 at 10:00 a.m. read in part, at approximately 2:50 p.m. (LVN K) contacted the facility to report that she observed (CR #1) walking near a restaurant (LVN K) stated that when she attempted to turn her vehicle around to</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained free of accident hazards, and each resident received adequate supervision to prevent accidents for 1 (CR #1) of 7 residents reviewed for accidents and supervision. The facility failed to ensure CR #1 did not leave the facility unattended on 3/21/25. CR #1 was found by another staff member approximately 1 mile away in a parking lot near the freeway. An immediate jeopardy (IJ) was identified on 10/22/25. The IJ template was provided to the facility on [DATE] at 5:01 p.m. While the IJ was removed on 10/24/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place residents at risk of accidents hazards. Findings include: Record review of CR #1's face sheet dated 10/22/25 revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on 6/27/25 to another nursing facility. His diagnosis included dementia, mood disorder, anxiety, and bilateral hearing loss. Record review of CR #1's Elopement Risk assessment dated [DATE] revealed he was not at risk for elopement/wandering. Record review of CR #1's admission MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15 which indicated moderate cognitive impairment. He was independent with ADLs and there was no wandering behavior exhibited. Record review of CR #1's care plan revealed he had impaired cognitive function/impaired thought processes related to dementia. Interventions were to discuss concerns about confusion and disease process and keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion, initiated 2/26/25. Record review of CR #1's Complete Evaluation/Psychosocial dated 2/26/25 written by the Psychologist indicated CR #1 had moderate cognitive loss. On exam he was cooperative and attentive with no gross behavioral abnormalities. The therapy content/clinical summary read in part, .he was open about memory, secondary to dementia. and depression about my (family member) left me recently, after she put me here. he talked about last few months at home being challenging with him wandering out of house and getting very frustrated with his cognitive challenges. Record review of CR #1's Physician/NP/PA/H&P progress note dated 3/6/25 written by NP V indicated the patient had severe deficits in cognition and memory. Record review of CR #1's behavioral complete evaluation dated 3/10/25 written by the Psychiatric Mental Health NP read in part, .Patient carries a diagnosis of dementia, anxiety and depression. Patient was seen in the common area ambulating. He reports my (family member) brought me here since I am not safe at home. Dementia: patient exhibits symptoms of dementia. Symptoms are observable. Onset: (CR #1's) symptoms were first noticed a few years ago. The first symptoms reported were: . got lost in familiar settings and began losing things. Course of illness: (CR #1's) symptoms have been slowly progressive. Recent symptoms suggest that cognitive deficits are moderately severe. His symptoms are chronically present during the whole day. (CR #1) exhibits the following moderate symptoms: He confabulates stories or details to hide defects in memory; restless behaviors like pacing. has increased; He cannot organize thoughts or follow logical explanations; poor judgment is creating safety issues when left alone. (CR #1's) memory problems are prominent. he forgets more frequently than previously. He loses track of what is happening . Exam: . His thoughts are loosely associated in a circumstantial way. Psychotic or borderline psychotic symptoms seem to be present. Disorganized behavior has been observed. Bizarre behavior has been observed. Delusional ideas are expressed. Paranoid ideas are expressed. moderate cognitive loss is present. this patient is not aware of current events. There is difficulty thinking abstractly. He does not correctly give the current date and time. He correctly gives his current location. He correctly gives his name. He is not aware of his current situation. Diffuse memory loss for recent and remote events is present. Periods of confusion with disorientation and memory problems are in evidence. (CR #1) presents as alert. Insight into problems appears to be poor. Judgment appears to be poor. There are signs of anxiety. A short attention span is evident. He is easily distracted. Record review of CR #1's progress note dated 3/11/25 written by NP Q revealed he was confused but was able to provide some insight on current complaints. Record review of an undated soft file document entitled CR #1 Investigation of events - leaving facility unattended provided by the facility on 10/23/25 at 10:00 a.m. read in part, at approximately 2:50 p.m. (LVN K) contacted the facility to report that she observed (CR #1) walking near a restaurant. (LVN K) stated that when she attempted to turn her vehicle around to reach the resident she lost visual contact and immediately</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 4 residents (Resident#1) reviewed for incontinent care.CNA A failed to wash Resident #1 external urethral orifice (the opening at the end of the urethra where urine exits the body) during perineal care (cleansing of the genital and anal areas to maintain hygiene).This failure could place residents at risk of infection and hospitalization. Findings included:Record review of Resident #1's face sheet dated 10/21/25 revealed a [AGE] year-old first admitted to the facility on [DATE] with diagnoses to include COPD (chronic obstructive pulmonary disease, a lung condition caused by damage to the airway), muscle weakness, abnormalities of mobility, cerebral vascular accident (stroke), anxiety and depression.Record review of Resident #1's quarterly MDS (a resident assessment and care screening tool) dated 08/19/2025 revealed a BIMS score of 15 indicating intact cognition. Resident #1 was dependent on staff for all ADLs including the ability to maintain perineal hygiene. Resident #1 was frequently incontinent of bowel and bladder.Record review of Resident #1's undated care plan included: Focus-Resident #1 has bowel and bladder incontinence which places him at risk for skin breakdown and UTI. Goal-Will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included - Brief Use: the resident uses disposable briefs. Change as needed. Incontinent: Check the resident during rounds and as required for incontinence. Wash, rinse and dry perineum.In an interview on 10/22/25 at 3:05PM, the DON stated pericare for both male and female should start with cleansing the urethra first, the actual opening should be cleansed then move further away from opening so not to bring bacteria to the opening of the urethra.Observation of peri care for Resident #1 on 10/24/25 at 6:45AM, revealed CNA A was walking down the hall and entered Resident #1's room. CNA A was holding white square patches in her hand. CNA A closed the door and gathered supplies. Resident #1 was alert, oriented and lying on his back with pillows under his knees watching TV. CNA A removed gloves from her pocket and put them on. CNA A told Resident #1 that she was going to clean him up. CNA A helped Resident #1 remove his pants, lowered the head of the bed, unfastened the tabs on the brief, used one disposable cleansing wipe and cleaned the left groin area. CNA A then cleansed right groin area with a clean wipe, disposed the wipe and with a clean wipe CNA A wiped from the base of the penis in the direction towards the tip of penis once. CNA A did not cleanse the external urethral orifice of the penis. CNA A assisted Resident #1 in rolling to his left side. Resident #1 had a bowel movement. CNA A cleansed the perineal area, buttocks then disposed of the soiled brief. CNA A removed gloves, disposed them into trash can, removed gloves from her pocket and put them on. CNA A proceeded with applying a clean brief and assisted the resident with dressing. CNA A and CNA F transferred the resident from the bed to the wheelchair. CNA A removed gloves. CNA A did not perform hand hygiene. CNA A assisted Resident #1 to the dining room by pushing the wheelchair using her hands. CNA A touched a chair and moved it, walked to where the ice chests were and lifted the lids using her hands then walked to the nurse station. CNA A then walked down the hall to Resident #1's room put on clean gloves and began to clean up.In an interview on 10/24/25 at 7:15 AM, CNA A stated the facility policy was to wash or sanitize hands prior to entering resident rooms and stated she did that when she was down the hall before entering Resident #1's room. CNA A stated she should have sanitized between glove changes for infection control and she did not do this because it skipped her mind. CNA A stated she kept gloves in her pocket because some rooms did not have her size gloves. CNA A stated she did not always keep gloves in her pocket. CNA A stated it was not hygienic to keep gloves in pockets and it was not an encouraged habit. CNA A checked the doorway and stated she didn't know there was a box of extra large gloves available. CNA A stated she did clean Resident #1's penis by wiping with cleansing cloth twice. CNA A stated she learned male peri care when she first stated working at the facility several months ago and had inservices on infection control and peri care for both male and female. CNA A stated she was supposed to perform hand hygiene prior to leaving Resident #1's room but got nervous. CNA A stated the risk of not doing hand hygiene was the germs from hands can get onto items touched and a resident could get infected if they touch the same items.In an interview on 10/27/25 at 12:30 PM, the DON stated she expected nursing staff to change gloves, sanitize or wash hands to prevent infection as much as possible any time they are working from a clean area to a dirty area such as during peri care. The DON stated the CNAs may have been rushing through their work and did not perform</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 8 resident (Resident #1) reviewed for pharmaceutical services. The facility failed to have an authorized staff administer medication to Resident #1. MA-I instructed CNA- A who was not authorized to apply Lidocaine patches to Resident #1's hips. The facility failed to clarify the physician order for Resident #1's Lidocaine patch as to which hip the patch was to be applied. CNA-A applied one patch to Resident #1's right hip and a second patch to the left thigh. This failure could place residents at risk of not receiving medications as ordered by the physician. This failure could place residents at risk of not receiving the desired therapeutic effects of their medications and uncontrolled pain. Findings included: Record review of Resident #1's face sheet dated 10/21/25 revealed a [AGE] year-old first admitted to the facility on [DATE] with diagnoses to include COPD (chronic obstructive pulmonary disease, a lung condition caused by damage to the airway), muscle weakness, abnormalities of mobility, cerebral vascular accident (stroke), anxiety and depression. Record review of Resident #1's quarterly MDS (a resident assessment and care screening tool) dated 08/19/2025 revealed a BIMS score of 15 indicating intact cognition. Resident #1 was dependent on staff for all ADLs. Record review of Resident #1's undated care plan included: Focus-Resident #1 was at risk for pain r/t generalized pain. Interventions included - administer analgesics as per ordered. Record review of Resident #1's physician order dated 03/17/2025 revealed a medication order for Lidocaine External Patch 4 %, apply to hip topically one time a day for pain and remove per schedule. Record review of Resident #1's October 2025 MAR (medication administration record) printed in 10/24/25 at 9:14 AM revealed Lidocaine External Patch 4%, Apply to hip topically one time a day for pain and remove per schedule was marked as administered on 10/24/25 at 8:00 AM by LVN J and not MA-I. Observation and interview of peri care for Resident #1 on 10/24/25 at 6:45AM, revealed CNA A was walking down the hall holding white square patches in her hand and entered Resident #1's room. CNA A closed the door and gathered supplies. Resident #1 was alert, oriented and lying on his back with pillows under his knees watching TV. CNA-A removed gloves from her pocket and put them on. CNA-A told Resident #1 that she was going to clean him up. CNA-A helped Resident #1 remove his pants, lowered the head of the bed, unfastened the tabs on the brief, and cleaned the front of Resident #1's peri area. Resident #1 stated the two Lidocaine patches were removed at nighttime and he gets new patches in the morning. CNA-A assisted Resident #1 in rolling to his left side. Resident #1 had a bowel movement. CNA-A cleansed the perineal area and buttocks then disposed of the soiled brief. CNA-A removed gloves, disposed them into trash can, removed gloves from her pocket and put them on. CNA-A proceeded with applying a clean brief. While Resident #1 was still on his left side, CNA-A applied a white patch to the right hip and fastened the tabs of the brief over the patch. Resident #1 rolled to his right side. CNA-A fastened the tabs of the brief on the left hip and applied the second white patch to the upper right thigh, below the brief. CNA-A stated they were pain patches, and the medication aide gave them to her so she could apply them onto Resident #1's skin. CNA-A removed gloves, disposed of them into trash can, removed gloves from her pocket and put them on then proceeded with helping Resident #1 get dressed. CNA-F entered the room and offered assistance. CNA-A and CNA-F transferred the resident from the bed to the wheelchair. CNA-A removed gloves. CNA-A assisted Resident #1 to the dining room by pushing him in the wheelchair. In an interview on 10/24/25 at 7:45 AM, MA-I stated she gave CNA-A two Lidocaine patches because she knew Resident #1 was getting peri care which was the opportunity to apply the Lidocaine patches before he got up and into the wheelchair. MA-I stated she was in the middle of dispensing medications for another resident. MA-I stated that once and awhile she would ask CNAs to help by applying the patches because she may not always get to him before he gets up out of bed. MA-I stated Resident #1 would complain of pain during the day if the Lidocaine patches were not put on before he gets up out of bed. MA-I stated the medication aides and nurses were responsible for administering the Lidocaine patches and that it was not policy to ask a CNA to apply them as she was the one signing off as administered. MA-I stated the patches should be applied to both hip areas where the brief would cover the hip. MA-I stated she was aware she made a mistake in giving the Lidocaine patches to the CNA. In an interview on 10/27/25 at 11:35AM, MA-I stated she did not sign out the Lidocaine patches for Resident #1 on 10/24/25 because someone else took over for her right after the incident and she</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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CNA A put on gloves from her pocket and not from the box of gloves in the room.CNA A failed to perform hand hygiene between glove changes during peri care, after pericare and before exiting Resident #1's room.These failures could affect residents at risk of infection and hospitalization.Findings included: Record review of Resident #1's face sheet dated 10/21/25 revealed a [AGE] year-old first admitted to the facility on [DATE] with diagnoses to include COPD (chronic obstructive pulmonary disease, a lung condition caused by damage to the airway), muscle weakness, abnormalities of mobility, cerebral vascular accident (stroke), anxiety and depression.Record review of Resident #1's quarterly MDS (a resident assessment and care screening tool) dated 08/19/2025 revealed a BIMS score of 15 indicating intact cognition. Resident #1 was dependent on staff for all ADLs including the ability to maintain perineal hygiene. Resident #1 was frequently incontinent of bowel and bladder.Record review of Resident #1's undated care plan included: Focus-Resident #1 has bowel and bladder incontinence which places him at risk for skin breakdown and UTI. Goal-Will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included - Brief Use: the resident uses disposable briefs. Change as needed. Incontinent: Check the resident during rounds and as required for incontinence. Wash, rinse and dry perineum.Record review of Resident #1's progress note written on 03/19/25 at 11:13AM by the MD revealed Resident #1 was hospitalized for pneumonia and UTI on 3/11/25.Record review of Resident #1's order summary report dated 10/23/25 revealed an order dated 08/15/25 to 8/22/25 for contact isolation for ESBL (extended Spectrum Beta-Lactamase is an enzyme produced by certain bacteria) in the urine.Record review of Resident #1's infection progress note written on 08/21/25 at 4:42 PM by LVN E revealed the resident was receiving a 7-day course of IV antibiotics for ESBL. Record review of Resident #2's face sheet dated 10/21/25 revealed a [AGE] year-old admitted to the facility on [DATE] and originally admitted on [DATE]. His diagnoses included chronic pulmonary edema (abnormal buildup of fluid in the lungs), diabetes, PVD (peripheral vascular disease: a slow progressive disorder of the blood vessels), aftercare following surgery on the nervous system, fracture of the vertebrae and anxiety. Record review of Resident #2's annual MDS dated [DATE] revealed a BIMS score of 9 out of 15 indicating moderate cognitive impairment. Resident #2 required substantial/maximum assistance with toilet hygiene. Resident #2 was frequently incontinent of bowel and bladder. Section M of the MDS revealed Resident #2 had a diabetic foot ulcer.Record review of Resident #2's undated care plan included: Focus - Resident #2 has bowel and bladder incontinence which places him at risk for skin breakdown and UTI. Interventions included - the resident uses disposable briefs, change as needed. Check the resident during rounds and as required for incontinence. Wash, rinse and dry perineum. Focus - Enhanced Barrier Precautions, at risk for infection r/t wounds. Interventions included - sanitize hands before entering and leaving the resident's room, wear gloves and gown during high-contact care activities for residents with indwelling medical devices, wounds. Focus - Resident #2 has actual impairment to skin integrity r/t diabetic ulcer to the left first toe. Interventions included - administer treatment as ordered, follow facility protocols for treatment of injury. Focus - Resident #2 has an ADL self-care performance deficit r/t weakness and Myasthenia Gravis (muscle weakness and fatigue). Interventions included Resident #2 required substantial/maximum assistance with transfers, use Hoyer (a mechanical lift).Record review of Resident #2's progress note dated 10/23/25 and written by RN G revealed Resident #2 had a reopened diabetic wound to toes on the left foot.Record review of Resident #3's face sheet dated 10/27/25 revealed a [AGE] year-old admitted to the facility on [DATE] and originally admitted on [DATE]. Her diagnoses included orthopedic aftercare following surgical amputation, paraplegia (paralysis of the legs and lower body), anemia, diabetes, obesity, neuromuscular dysfunction of the bladder (when an injury or disease interrupts the electrical signals between your nervous system and</p>		