

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Thrive Rehabilitation of Pearland		STREET ADDRESS, CITY, STATE, ZIP CODE 3406 Business Center Drive Pearland, TX 77584	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059</p> <p>Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 2 of 2 resident reviewed for resident rights. (Resident #1 and Resident #2)</p> <p>Resident #1 and Resident #2 did not have a privacy covering on their catheter bags.</p> <p>This failure could place residents with urinary catheters at risk for decreased quality of life and self-esteem.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Record review of Resident #1's Face Sheet dated 8/14/24 reflected a [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with the diagnoses of: indwelling foley/catheter, tracheostomy (surgical procedure that involves creating an opening in the neck to access the trachea, or windpipe), Epilepsy (seizures are caused by abnormal electrical activity in the brain), traumatic brain injury, respiratory failure, quadriplegic (paralysis of all four limbs), and g-tube dependent (dependent on a gastrostomy tube (G-tube) for nutrition),</p> <p>Record review of Resident #1's physician orders dated 8/14/24 reflected Resident #1's indwelling foley catheter should be in a privacy bag and catheter leg strap on at all times and manage change foley catheter, bag, and/or tubing as needed for .leakage and/or infection.</p> <p>Record review of Resident #1's care plan dated 8/14/2024 reflected the following in part:</p> <p>Focus - Resident #1 has catheter .</p> <p>Goal - Catheter related trauma will be minimized though the review date.</p> <p>Interventions - Check tubing for kinks, monitor and document intake and output as per facility policy, .</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's discharge MDS assessment dated [DATE] (8/12/24 admission MDS in progress) reflected Resident #1 had a BIMS score of 00 which indicated he was severely impaired cognitively. Resident #1 had an indwelling catheter.</p> <p>Observation on 8/14/24 at 8:44 a.m. of Resident #1 revealed resident lying in bed on his back and his clear catheter bag was sitting on the floor. Resident #1's catheter bag did not have a privacy bag cover. The urine in the bag was visible from the doorway</p> <p>Interview on 8/14/24 at 8:59 a.m. with Med Aide A said she had not been in Resident #1's room. She walked in Resident #1's room and said he needed a privacy bag.</p> <p>Interview on 8/14/24 at 9:05 a.m. with LVN A in Resident #1's room, said Resident #1's catheter bag should have a privacy cover. She said the privacy bag was to maintain the resident's dignity. She said the privacy bag was not in place because Resident #1 was recently admitted from the hospital. She said the nurse was responsible for changing out the catheter bags and privacy covers. She said the facility did not have separate privacy covers to use over the hospital catheter bags and would have to change out the hospital bag with the facility catheter bag that had a built-in cover.</p> <p>Interview on 8/14/24 at 9:12 a.m. with the DON said she was not aware Resident #1's catheter bag did not have a privacy cover. She said the nurse should have ensured the privacy cover was in place. She said staff had been in-serviced and trained on catheter care. She said the nurses and CNAs perform frequent rounds to ensure resident needs were met. She said the staff round every two hours.</p> <p>Interview on 8/14/24 at 1:19 p.m. with LVN C said he admitted Resident #1 and did not place a privacy cover over the catheter bag. He said he would have needed to change the catheter bag to the ones the facility had with a built-in privacy cover. He said was focused on the new admission process for Resident #1 and not the privacy cover. He said he was responsible for ensuring the privacy bag was in place.</p> <p>Resident #2</p> <p>Record review of Resident #2's Face Sheet dated 8/14/24 reflected a [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with the diagnoses of: intestinal obstruction, foley/catheter, tracheostomy (surgical procedure that involves creating an opening in the neck to access the trachea, or windpipe), acute respiratory failure, stage one through four chronic kidney disease, epilepsy (seizures are caused by abnormal electrical activity in the brain) and g-tube dependent (dependent on a gastrostomy tube (G-tube) for nutrition).</p> <p>Record review of Resident #2's physician orders dated 8/14/24 reflected Resident #2 had a foley catheter. Foley catheter to continuous drainage. Change for obstruction as needed.</p> <p>Record review of Resident #2's care plan dated 8/14/2024 reflected the following in part:</p> <p>Focus - Resident #2 at risk for complications related to indwelling catheter.</p> <p>The care plan did not include privacy related to catheter privacy cover.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's admission MDS assessment dated [DATE] reflected Resident #2 had a BIMS score of 00 which indicated he was severely impaired cognitively. Resident #2 had an indwelling catheter.</p> <p>Observation and Interview on 8/14/24 at 12:25 p.m. of Resident #2 revealed the resident lying in bed and his catheter bag was visible from the door. The catheter bag was half full. CNA A entered the room and said he was not sure why the catheter bag did not have a privacy cover. He said because the privacy cover was not in place, the resident's dignity was not maintained. He said he was not aware of a separate privacy cover to place over the exposed catheter bag. The family member in the room said there had not been a privacy cover during family visits or previous visits.</p> <p>Record review of the facility's policy on Indwelling Catheter Care (dated 2/2017) revealed the following in part: Purpose: to ensure the care of the urinary catheter is carried out in a manner that minimizes trauma and infection risk Procedure/Implementation: .7. Provide privacy . 24. Maintenance .c. Keep drainage bag off the floor.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059</p> <p>Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 1 (Resident #1 of 2 residents reviewed for incontinent care and for indwelling urinary catheters.</p> <p>Resident #1's catheter bag and tubing were sitting on the floor and the catheter bag was leaking.</p> <p>These failures could place residents with urinary catheters at risk for infections and injuries.</p> <p>The findings included:</p> <p>Resident #1</p> <p>Record review of Resident #1's Face Sheet dated 8/14/24 reflected a [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with the diagnoses of: indwelling foley/catheter, tracheostomy (surgical procedure that involves creating an opening in the neck to access the trachea, or windpipe), Epilepsy (seizures are caused by abnormal electrical activity in the brain), traumatic brain injury, respiratory failure, quadriplegic (paralysis of all four limbs), and g-tube dependent (dependent on a gastrostomy tube (G-tube) for nutrition),</p> <p>Record review of Resident #1's physician orders dated 8/14/24 reflected Resident #1's indwelling foley catheter should be in a privacy bag and catheter leg strap on at all times and manage change foley catheter, bag, and/or tubing as needed for .leakage and/or infection.</p> <p>Record review of Resident #1's care plan dated 8/14/2024 reflected the following in part:</p> <p>Focus - Resident #1 has catheter .</p> <p>Goal - Catheter related trauma will be minimized though the review date.</p> <p>Interventions - Check tubing for kinks, monitor and document intake and output as per facility policy, .</p> <p>Record review of Resident #1's discharge MDS assessment dated [DATE] (8/12/24 admission MDS in progress) reflected Resident #1 had a BIMS score of 00 which indicated he was severely impaired cognitively. Resident #1 had an indwelling catheter.</p> <p>Observation on 8/14/24 at 8:44 a.m. of Resident #1 revealed resident lying in bed on his back and his clear catheter bag was sitting on the floor. There was some liquid next to the bag. The catheter bag was full, and some urine was in the tubing.</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>Interview on 8/14/24 at 8:59 a.m. with Med Aide A said she had not been in Resident #1's room. She walked in Resident #1's room and said the catheter bag should not have been on the floor. She said Resident #1 would be at risk for infection. She said the nurses and CNAs were responsible and should have ensured the catheter bag was hung on the side of the bed. She said she had been trained on catheter care and was aware the resident's bag should not have been on the floor.</p> <p>Interview on 8/14/24 at 9:05 a.m. with LVN A in Resident #1's room, said Resident #1's catheter bag should not have been on the floor. She said the bag had a leak. She said she had not been in his room today. She said Resident #1 was at risk from infection due to cross contamination. She said he could develop a UTI. She said the nurse was responsible for changing out the catheter bags and privacy covers.</p> <p>Interview on 8/14/24 at 9:12 a.m. with the DON said she was not aware Resident #1's catheter bag was on the floor. She said the nurse should have ensured the catheter bag was not on the floor. She said Resident #1 was at risk for infection because the catheter bag was on the floor. She said staff had been in-serviced and trained on catheter care. She said the nurses and CNAs perform frequent rounds to ensure resident needs were met. She said the staff round every two hours.</p>