STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676436	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thrive Rehabilitation of Pearland	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide and document sufficient preparation and orientation to resident or resident's family member on the facility bed-hold policies for 1 of 5 residents (Resident # 1) reviewed for discharge. S/S 1/D Based on interview and record review, the facility failed to provide discharge notice and document sufficient preparation and orientation to residents or resident's family member on the facility's bed -hold policies for 1 of 5 Residents (Resident # 1) reviewed for discharge rights. This failure could place residents at risk of not receiving notice of the facility's bed hold policy during transfer from the facility to a hospital which could result in anxiety, distress and displacement. Findings included: Record review of Resident # 1's face sheet dated 07/23/2025 revealed she was a [AGE] year old female admitted [DATE] with the following medical diagnoses: rheumatoid arthritis9 a chronic autoimmune disease that causes inflammation in the joints) restless legs(an irresistible urge to move the legs, typically accompanied by unpleasant sensation) tinea unguinous (a fungal infection of the nail), anemia,(lower-than-normal level of red blood cells) immunodeficiency due to drugs, (a person's immune system has a reduced ability to fight off infections as a result of taking certain medications) d deficiency, obesity, multiple sclerosis, myelin oligodendrocyte (protein found on the brain and spinal cord), migraine, insomnia, narcolepsy (excessive daytime sleepiness),carpal tunnel syndrome of the left upper limb, lesion of lateral popliteal (damage to the nerve that causes foot drop), hereditary and idiopathic neuropathies (nerve damage of undetermined cause), Guillain-Barre syndrome (weakness, numbness and paralysis), chronic pain, visual disturbance, asthma, gastro-esophageal reflux disease (stomach acid flowing back into the esophagus), calculus of bladder without obstruction(bladder stone without obstruction), sacroiliitis (painful, inflammation and stiffness of the joints), cervical disc displacement, radiculopathy (pinched nerve), generalized muscle weakness, shortness of breath, wound infection and traumatic brain injury (brain injury caused by external force, which can result to temporary or permanent impairment). Record review of Resident #1's MDS assessment dated [DATE], revealed she had a BIMS score of 12,which indicated she had moderate cognitive impairment. Section A0310 F, assessment type for entry/discharge report was coded 11, indicating discharge assessment with return anticipation. Section A0310 G, type of discharge was coded 2, indicating unplanned discharge. Record review of resident #1 s care plan dated 07/23/2025, revealed an Activities of daily living self-care performance deficit with bowel incontinence that required a check every two hours and assistance with peri care after each incontinence episode. Record review of the NP's documentation dated 07/28/2025 ,revealed Resident #1 was assessed for abdominal pain, fleet enema (a pre-filled saline laxative used to relieve occasional constipation by drawing water into the colon to soften stool and stimulate a bowel movement within one to five minutes) , blood work and STAT KUB (a kidney, ureter and bladder x-ray to assess the abdominal area for causes of abdominal pain) was ordered. Record review of the facility progress notes, dated 07/28/2025, for Resident # 1 revealedno discharge order, discharge summary, or handwritten progress note from the physician to reflect the details of the discharge. During an interview with Resident # 1 on 10/8/2025 at 11:07a.m, she stated the facility coordinator promised her if she ever went to the Emergency Room, she would be allowed to return to the facility. Resident # 1 said: I found out later that; while I was at the hospital, they discharged me from the facility. One of the counselors from the hospital came to my hospital room to talk to me. The counselor said when she called the facility when I was getting close to discharge, the facility told the counselor, I was not allowed to come back. I called the facility to ask why I could not come back; I was told it was because I was refusing care and complaining too much. I anticipated returning to the facility, because they promised me at the beginning if I ever go to the ER, I would be able to come back. Resident # 1 stated she did not pack her belongings out of the room because she was not notified, she was not allowed to return. Resident # 1 stated her family member made a special trip to the facility to pack and remove her belongings from the facility.During an interview with the admission Coordinator on 10/08/2025 at 3:04 p.m., she stated the resident had called her from the hospital, and she told her she was not allowed to return to the facility due to aggressive behavior and she was non-compliant with treatment when she refused an enema ordered by the NP on the day she went to the ER. The coordinator stated, during the facility's morning meetings, they discussed residents' behaviors such as yelling at staff. The admission Coordinator stated Resident #1 yelled and screamed at the staff. The admission Coordinator said, Resident # 1's family member yelled and screamed at the front desk. The coordinator said

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop a person-centered care plan to meet practicable physical needs for 1 (Resident #2) reviewed for care plans. Based on record reviews and interviews facility failed to develop or implement a care plan with goals or interventions related to use of adaptive devices for Resident # 2. On 10/23/2025 at 05:05 p.m., an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/24/2025, the facility remained out of compliance at a severity level of isolation with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place Residents at risk of not receiving necessary care and services for not having their individual medical, physical, psychological and/or emotional needs met. Findings included: Record review of Resident # 2's face sheet dated 08/18/2025, revealed an [AGE] year-old male admitted on [DATE] following a joint replacement surgery on 06/25/2025. His diagnoses included: joint replacement surgery, type 2 diabetes(high levels of sugar in the blood stream), hypertension (high blood pressure), parathyroid(overactive thyroid glands), hyperlipidemia (high levels of fat in the blood stream), dementia, depression, degenerative disease of nervous system, epilepsy (repeated seizures caused by damaged brain cells), Transient-Cerebral Ischemic Attack (brief blockage of blood flow to the brain), generalized muscle weakness, acute kidney failure, dysphagia (difficulty swallowing), tremors, lack of coordination, cognitive communication deficit (communication challenge caused by problem with thinking abilities like attention, memory, and executive function rather than a language or speech problem), fracture of left femur(fracture of the hip bone), closed fracture with routine healing (a non-surgical procedure used to align and immobilize broken bones without the need for surgery. Resident # 2 was initially admitted on [DATE]. Record review of Resident # 2's MDS dated [DATE], cognition section C0400 was coded 1 which indicates able to recall after cueing. Cognition section C0500 was coded 06, which indicated severe cognitive impairment. Record review of Resident # 2's care plan dated 08/15/2025 revealed Resident # 2 had a fracture with goal to remain free of complication related to hip fracture, such as contracture formation, embolism (obstruction of an artery, typically by a clot of blood or an air bubble) and immobilization. Resident # 2 had ADL self-care performance deficit with the following intervention: needs transfer with two people assisting from bed to chair or vice versa.Record review of Resident # 2's hospital discharged paperwork, dated 06/25/2025 revealed, gait assistance, needs two person assist with a gait belt, maximal assistance. Scooting: needs two total assistance (sitting and supine scooting). Sit to supine: total assistance. Needs two. Precautions: fall precautions, posterior hip precautions. Abdominal pillow in the lower extremity while in bed, as well as hip abduction pillow. Pillow for hip replacement surgery for leg support and prevention of dislocation. Record review of facility's New admission Report Sheet, dated 06/25/2025, did not reveal any special equipment or type of assistance needed during transfer for Resident # 2.Record review of Resident # 2's admission report dated 06/25/2025, revealed no special equipment, amount or type of mobility assistance for transfer. Record review of Resident # 2's baseline care plan, dated 06/25/2025, revealed no special or adaptive devices such as a hip abduction pillow, wedge or cushion to be used. Resident # 2's care plan indicated he had a fracture with goal to remain free of complications related to hip fracture, such as contracture formation, embolism (obstruction of an artery, typically by a clot of blood or an air bubble) and immobilization. Resident # 2's care plan for ADL self-care deficit with the following intervention: transfer with two people assisting from bed to chair and vice versa. Record review of Resident # 2's Physician orders revealed no special adaptive devices like a hip abduction pillow, wedge or cushion to be used for proper body alignment. Record review, of Resident # 2's electronic health revealed no use of special or adaptive devices. Further review revealed no precautions or interventions related Resident # 2's hip or transferring assistance.Record review of video placed by family member in Resident # 2's room, dated 07/07/2025, at 3:20 p.m. revealed CNA C transferred Resident # 2 without a second person assist. In the video, CNA C said, I am going to transfer you by myself. The video revealed CNA C transferred Resident # 2 from a wheelchair to his bed without using a gait belt. CNA C left the cushion in between Resident # 2's legs. CNA C removed the cushion from between his legs as he was sitting up in bed with pillows behind him. CNA C proceeded to remove his pants; CNA C, pushed on the left side of his legs on knees. Resident # 2 said whoa whoa. CNA C said, I am just taking your pants off and then pushed on his right side of his legs on knees to lower his pants. CNA C then put the cushion back between his legs. Record review of hospital care team

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide adequate supervision to prevent accidents for 1 (Resident # 2) of 1 resident reviewed for accident and supervision. Based on record reviews and interviews, the facility failed to ensure adequate supervision when CNA C transferred Resident # 2 alone using a stand and pivot method instead of a two-person transfer. The facility failed to ensure CNA C improperly transferred Resident # 2 by performing a two person transfer alone using a stand and pivot method on 07/07/2025 at 15:20 p.m. On 10/23/2025 at 05:05 p.m., an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/24/2025, the facility remained out of compliance at a severity level of isolation with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their plan of Removal. This failure could place residents at risk for experiencing pain, injuries, bruises, dislocation and fracture from possible accidents which could result in a diminished quality of life and hospitalization. Findings included: Record review of Resident # 2's face sheet dated 08/18/2025, revealed an [AGE] year-old male admitted on [DATE] following a joint replacement surgery on 06/25/2025. His diagnoses included: joint replacement surgery, type 2 diabetes(high levels of sugar in the blood stream), hypertension (high blood pressure), parathyroid(overactive thyroid glands), hyperlipidemia (high levels of fat in the blood stream), dementia, depression, degenerative disease of nervous system, epilepsy (repeated seizures caused by damaged brain cells), Transient-Cerebral Ischemic Attack (brief blockage of blood flow to the brain), generalized muscle weakness, acute kidney failure, dysphagia (difficulty swallowing), tremors, lack of coordination, cognitive communication deficit (communication challenge caused by problem with thinking abilities like attention, memory, and executive function rather than a language or speech problem), fracture of left femur(fracture of the hip bone), closed fracture with routine healing (a non-surgical procedure used to align and immobilize broken bones without the need for surgery. Resident # 2 was initially admitted on [DATE]. Record review of Resident # 2's MDS dated [DATE], cognition section C0400 was coded 1 which indicated able to recall after cueing. Cognition section C0500 was coded 06, which indicated severe cognitive impairment.Record review of Resident # 2's care plan dated 08/15/2025 revealed Resident # 2 had a fracture with a goal to remain free of complications related to hip fracture, such as contracture formation, embolism (obstruction of an artery, typically by a clot of blood or an air bubble) and immobilization. Resident # 2 had ADL self-care performance deficit with the following intervention: needs transfer with two people assisting from bed to chair or vice versa. Record review of video placed by family member in Resident # 2's room, dated 07/07/2025, at 3:20 p. m. revealed CNA C transferred Resident # 2 without a second person assist. In the video, CNA C said, I am going to transfer you by myself. The video revealed CNA C transferred Resident # 2 from a wheelchair to his bed without using a gait belt. CNA C left the cushion in between Resident # 2's legs. CNA C removed the cushion from between his legs as he was sitting up in bed with pillows behind him. CNA C proceeded to remove his pants; CNA C, pushed on the left side of his legs on knees. Resident # 2 said whoa whoa. CNA C said, I am just taking your pants off and then pushed on his right side of his legs on knees to lower his pants. CNA C then put the cushion back between his legs. Record review of hospital care team progress notes revealed: on 07/09/2025 at 1:45 p.m., radiographs for orders placed on 07/09/2025 for bilateral (both) hips shows dislocation of the right total hip arthroplasty (a surgical procedure that involves creating, repairing, or replacing a damaged or diseased joint with an artificial joint called a prosthesis). There is a left hip hemiarthroplasty (a surgical procedure that replaces only half of a damaged joint, most commonly the hip with a prosthetic) without acute changes. The care team advised Resident # 2 be taken to the ED for attempt to close the reduction with possibility of OR if unable to reduce in the ED. During an interview with CNA A, on 10/08/2025 at 2:19 pm, she said if a resident required two staff members during transfer and only one staff member was used, the resident might fall. During an interview with the MDS Coordinator on 10/08/2025 at 2:32 p.m., he stated Resident 2 #'s care plan did not change because the facility does not change care plans when residents return from hospitalization. He said the only update would be medication changes. He said there were no changes made to Resident # 2's care plan. During an interview with the DON, on 10/08/2025 at3:18 pm, she stated an inappropriate transfer might result to an injury, or death. During an interview with CNA B on 10/08/2025 at 4:20 pm, she stated that Resident # 2 required two staff during transfer. She said if one staff member attempted to transfer Resident # 2, he might be injured and that might lead to a change in condition. During an interview with RN A on 10/08/2025 at 5:11 p.m., she stated Resident # 2 required two

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility staff failed to ensure residents received treatment and care in accordance with professional standards of practice in performing physician ordered daily pain monitoring for 1 of 3 residents (Resident # 2) reviewed for pain assessment. Based on record reviews and interviews the facility failed to ensure Resident # 2 was assessed for pain according to physician's orders on 07/07/2025 and 07/08/2025.This failure could place, dependent residents at risk of experiencing pain, injuries, bruises, and fractures from possible accidents which could result in a diminished quality of life and hospitalizationFindings include: Record review of Resident # 2's face sheet dated 08/18/2025, revealed an [AGE] year-old male admitted on [DATE] following a joint replacement surgery on 06/25/2025. His diagnoses included: joint replacement surgery, type 2 diabetes(high levels of sugar in the blood stream), hypertension (high blood pressure), parathyroid(overactive thyroid glands), hyperlipidemia (high levels of fat in the blood stream), dementia, depression, degenerative disease of nervous system, epilepsy (repeated seizures caused by damaged brain cells), Transient-Cerebral Ischemic Attack (brief blockage of blood flow to the brain), generalized muscle weakness, acute kidney failure, dysphagia (difficulty swallowing), tremors, lack of coordination, cognitive communication deficit, fracture of left femur(fracture of the hip bone), closed fracture with routine healing(a non-surgical procedure used to align and immobilize broken bones without the need for surgery.Record review of Resident # 2's MDS dated [DATE], cognition section C0400 was coded 1 which indicated able to recall after cueing. Cognition section C0500 was coded 06, which indicated severe cognitive impairment. Record review of Resident # 2's care plan dated 08/15/2025 revealed Resident # 2 had a fracture with a goal to remain free of complications related to hip fracture, such as contracture formation, embolism (obstruction of an artery, typically by a clot of blood or an air bubble) and immobilization. Resident # 2 had ADL self-care performance deficit with the following intervention: needs transfer with two people assisting from bed to chair or vice versa. Record review of Resident # 2 Physician Orders dated 6/25/2025 revealed Pain Monitoring using verbal/nonverbal 0 -10 scale. Frequency: every shift everyday. Start Date:6/25/2025 - End Date: indefinite (Discontinued 7/14/2025).Record review of facility Physician progress notes dated 7/2/2025 revealed Assessment/Plan: 85 you male, with deficits in mobility, endurance and ADLs secondary to left hip FX , S/P repair. Pain due to fracture, neuropathy. New Problem: Impact on therapy causing imbalance, instability, decreased strength. Workup: Continue with PT/OT. Emphasis on AD training, static and dynamic balance training, functional activity tolerance, sensorimotor skills, increase body awareness, improve range of motion, strengthening, endurance training and neuromuscular training and control. Record review of Resident # 2's MAR, dated 07/ 2025 revealed Acetaminophen two tablet by mouth every six hours as needed for Headache: Pain. Tramadol HCl Give one tablet by mouth every 6 hours as needed for pain did not reveal pain level documented in MAR. Further review of progress notes, assessments, or vitals did not reveal notes for Pain Monitoring or Pain Level for dates 7/7/2025 - 7/8/2025. Record review of video placed by family member in Resident # 2's room, dated 07/07/2025, at 3:20 p.m. revealed CNA C transferred Resident # 2 without a second person assist. In the video, CNA C said, I am going to transfer you by myself. The video revealed CNA C transferred Resident # 2 from a wheelchair to his bed without using a gait belt. CNA C left the cushion in between Resident # 2's legs. CNA C removed the cushion from between his legs as he was sitting up in bed with pillows behind him. CNA C proceeded to remove his pants; CNA C, pushed on the left side of his legs on knees. Resident # 2 said whoa whoa. CNA C said, I am just taking your pants off and then pushed on his right side of his legs on knees to lower his pants. CNA C then put the cushion back between his legs. Further review of the video did not reveal CNA C assessing Resident # 2 for pain using verbal or non-verbal scale. Further review did not reveal CNA C informing a facility nurse to assess Resident # 2 for pain. During an interview on 10/22/2025 at 10:45 a.m., CNA D said she worked with Resident # 2 sometimes, when she helped his aide, CNA C. CNA D said Resident # 2 could not verbalize pain and he could only whisper certain words. CNA D said, she could tell if Resident # 2 was in pain because of his facial grimaces. CNAF said if any nonverbal resident was in pain, he or she would make facial grimaces. During an interview 10/22/2025 at 2:41 p.m., CNA F said Resident # 2 was moved from 100 hall to 600 hall. CNAF said when she provided care to Resident # 2, she had to be careful during repositioning. She said Resident # 2 could verbalize his pain. CNA F said she could not recall Resident # 2 exhibiting any signs of pain when she took care of him. During an interview on 10/23/205 at 10:38 a.m., the Administrator said, the CNA's get a