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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thrive Rehabilitation of Pearland	3406 Business Center Drive Pearland, TX 77584

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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	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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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** Based on interview and record review, the facility failed to provide notice as soon as practicable before transfer or discharge for 1 of 5 residents reviewed for admission, transfer, and discharge. -CR #1 was notified on 10/07/25 that she had to transfer to another facility or discharge somewhere else by 10/07/25. This failure could place residents at risk of not receiving appropriate care and required notifications being made. Findings included: Record review of CR #1's admission Record, dated 10/14/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke), muscle weakness, unspecified lack of coordination, type 2 diabetes mellitus with hyperglycemia (high levels of blood sugar in the blood), morbid (severe) obesity (abnormal or excessive fat accumulation) due to excess calories, and functional quadriplegia (complete inability to move due to severe disability or frailty resulting from conditions such as severe obesity or other debilitating diseases). Record review of CR #1's Discharge MDS Resident Assessment, dated 10/07/25, Section A, revealed a planned discharged on 10/07/25, to home/community. Further review revealed a BIMS score of 15, indicating intact cognition. Section GG, Functional Abilities, revealed resident required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe, upper and lower body dressing, and personal hygiene. Record review of CR #1's Care Plan report, undated, revealed resident was non-compliant with facilities non-smoking policies. Interventions included medications as ordered and to observe behaviors and try to determine cause. Record review of CR #1's progress notes, dated 10/07/25 at 11:56 a.m., entered by Admissions, read in part pt was notified on 10/03/25 that we are a non smoking facility per pt she know (sic) and she has not been smoking inside, provided a copy of do not bring in items and put it on top of the dresses below tv. Record review of CR #1's progress notes, dated 10/07/25 at 11:59 a.m., entered by Social Services - Social Worker, read Due to patient being caught with a vape, she was advised that the facility can assist with finding another facility that can accommodate her smoking, or we can discharge her home with home health services. Patient stated she needs time to think. SW will follow up. Record review of CR #1's progress notes, dated 10/08/25 at 17:44 (5:44 p.m.), entered by Social Services - Social Worker, read On 10/07/25, Patient decided to discharge home with HH services. SW set up HH services and ordered a wheelchair for the patient. SW will follow-up. Record review of CR #1's Discharge IDT Recapitulation of Stay assessment, dated 10/07/25, reflected discharge location was to a hotel. Record review of CR #1's clinical records revealed no discharge notice or notice sent to ombudsman. During a telephone interview on 10/14/25 at 10:54 a.m., CR #1 said her discharge was facility initiated, that she was safe, discharged with her medications, and discharged home with her family members, she believed this past Tuesday, 10/07/25. She said the facility did not give her much of a choice and told her on 10/07/25 that she had to leave. She said CNA A reported to staff that she was smoking in her room on Friday, and the Social Worker told her she could not smoke in her room. She said the Social Worker told her that that her significant other told him CR #1 admitted to smoking. She said the facility sent her paperwork to another facility, in a different town, that allowed smoking but said she told the Social Worker she did not want to go to that facility. She said the Social Worker told her she had to be discharged home or to the other facility because she was a smoker. She said she asked if she could stay if she agreed not to smoke and was told no. She said she requested to be sent to a different facility but was told by the Social Worker she could not go to the facility that she requested. During an interview on 10/14/25 at 11:33 a.m., the Social Worker said CR #1 was a smoker and they were a non-smoking facility. He said the transfer was facility initiated but the discharge home was resident initiated. He said they let CR #1 know she could be discharged to another facility or home because they found a vape, cigarette butts, and cigar fillings, in her room. He said the resident and her family made the decision to discharge because she did not want to stop smoking. He said they gave her a 24-48-hour notice to go to another facility, because she had violated the smoking policy, but she did not want to go. During a follow-up interview on 10/14/25 at 1:07 p.m., the Social Worker said on 10/03/25 the resident was allegedly smoking in the courtyard, right outside her room, and given the smoking policy by the Admissions Coordinator. He said on 10/07/25, CNA said resident was found with a weed vape and that she was smoking. He said on 10/07/25 he went to the resident's room around 4:30/5:00 p.m. and he told the resident she was accepted to another facility, but they only had semi-private rooms, and since her family could not go with her, she did not want to go. He said she got a hotel room for 2 days and was not sure what she did after

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 1 of 7 residents (Resident #3) reviewed for care plan revisions.- The facility failed to ensure Resident #3's care plan was updated to reflect his new diet of Level 4 (food is pureed smooth with no lumps or bumps) pureed after a choking incident (7/31/25) and had Level 6 (food cut into small, bite sized pieces that are tender and soft) soft and bite sized on 9/26/25.This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included:Record review of Resident #3's undated face sheet revealed he was a [AGE] year old male admitted on [DATE] with diagnoses of dysphagia (trouble swallowing), chronic kidney disease (kidneys are not filtering well), muscle weakness, type 2 diabetes mellitus (body does not produce insulin or resists it), and cognitive communication deficit (difficulty with communication skills caused by impairments in thinking processes).Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 out of 15, which indicated moderately impaired cognition. The MDS revealed the resident had a mechanically altered diet which required a change in the texture of food, like a pureed diet. It also revealed he was receiving Speech Therapy.Record review of Resident #3's Care Plan dated 6/25/23, revealed a Focus: Resident had a swallowing problem r/t difficulty with thin liquids. Diet: Renal/LCS Level 6 soft & bite sized texture, Level 0 (no modification) thin consistency. The goal was for the resident to not have any choking episodes when eating through the review date (Target Date: 3/8/25). Interventions included for the staff to be informed of the resident's special dietary and safety needs, the diet to be followed as prescribed, keeping the head of the bed elevated for 45 degrees during the meal and 30min after, monitoring for SOB or choking, and for the resident to eat with supervision.Record review of Resident #3's Change in Condition Note dated 7/31/25 at 5:52pm by RN G, revealed the resident was in the dining room eating dinner when he started choking. He was found blue, and unresponsive, so CPR was initiated. A chest thrust produced food particles in the back of the resident's throat, so a finger sweep was performed and the resident gasped. The resident was then transferred to the hospital.Record review of Resident #3's ER Notes dated 7/31/25 at 5:16pm by MD L, revealed .Per EMS, nursing home staff saw him choking and put him down from his wheelchair and started doing chest compressions. After 2 to 3 minutes of chest compressions a piece of food came up from his mouth and a finger sweep was done. Once EMS got there patient had his own pulse and was breathing. They are unsure if he ever lost his pulses. Patient now is awake and alert and breathing on his own.Record review of Resident #3's Physician Orders from MD T, revealed an order for Renal/LCS diet, Level 4 puree texture, Level 0 thin consistency. Ordered on 8/1/25.Record review of Resident #3's Nurse's Note dated 8/1/25 at 6:00pm by RN A, revealed the resident's diet had been changed to pureed and a Speech Therapy consult was entered.In an interview on 9/26/25 at 9:53am, Resident #3 said he remembered choking on a piece of meat, but he did not remember what it was. He said he did not remember what happened after he started choking. Resident #3 said he was on a pureed diet now.In an interview on 9/26/25 at 4:25pm, the DON said nursing staff would be responsible for updating the Care Plan with the correct diet. She said she did not know why it was not updated. She did not think anything would happen to the resident since the diet order in the chart was correct.Record review of the facility's policy and procedure on Comprehensive Plan of Care (Updated December 2016) read in part: It is the policy of this facility to provide each resident with a comprehensive plan of care developed that includes goals, measurable objectives and timetables to meet their medical, nursing, mental, psychosocial needs identified during comprehensive assessment. The comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive plan of care will include: Address the resident's individual needs, strengths, and preferences.Be periodically reviewed and revised by the interdisciplinary team as changesin the resident's care and treatment occur. The Director of Nurses (DON) and/or its designee shall be responsible for implementation of this policy. Re-evaluate and modify care plans as necessary to reflect changes in care, service and treatment, quarterly, and with significant change in status assessment. Care plan evaluation must occur in response to changes in the resident'sphysical, emotional, functional, psychosocial, or communicative status as they occur, as well as following the RAI guidelines.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 of 7 residents (Resident #5) reviewed for oxygen.- The facility failed to ensure Resident #5 had a physician's order for oxygen, when he was being administered 3L O2 via NC on 9/26/25.This failure could place residents at risk for inadequate or inappropriate amounts of oxygen delivery and ineffective treatment.Findings included:Record review of Resident #5's undated face sheet revealed he was an [AGE] year-old male admitted on [DATE] with diagnoses of heart failure (heart does not pump effectively), seizures, and chronic kidney disease (kidneys do not filter). The picture of the resident on the face sheet revealed he had oxygen on via NC.Resident #5's MDS assessment had not been completed yet.Record review of Resident #5's Baseline Care Plan dated 9/20/25 by the DON, revealed the resident was receiving oxygen under Therapy and Nursing Services. Record review of Resident #5's previous hospital records dated 9/15/25 at 7:16am by MD K, revealed the resident was on 3 L/min O2 via NC.Record review of Resident #5's admission summary dated [DATE] at 7:47pm by unknown nurse, revealed the resident was on continuous oxygen.Record review of Resident #5's Physician Orders by MD B, reviewed on 9/26/25, revealed no orders listed for oxygen.In an interview and observation on 9/26/25 at 9:59am, Resident #5 was sitting up in bed with family present. He had 3L O2 via NC on. The resident said he was on continuous oxygen and used it continuously at home as well.In an interview on 9/26/25 at 12:40pm, RN A said he knew how much oxygen to put a resident on by looking at the order in the chart. He said the oxygen administration was also documented in the MAR-TAR. He said there was not an order for Resident #5's oxygen but he knew he was on 3L. He did not know why there was not an order for the oxygen. He said if someone was taking care of the resident and did not know him well, they would not know how much oxygen he was supposed to be on. RN A called the DON and informed her the resident was on 3L O2 via NC and there was not an order. She told him to go ahead and put an order in for it. In an interview on 9/26/25 at 4:25, the DON said if there was not an order in the resident's chart it could cause harm, or the resident could miss treatment.Record review of the facility's policy and procedures on Oxygen Administration, Nasal Cannula (Updated August 2017) read in part: It is the policy of this facility to provide oxygen support when indicated via appropriate delivery device to achieve or maintain adequate oxygenation to the respiratory compromised resident.Oxygen is a drug and as such there must be a physician's order for its use.Document O2 administration in Nurses Notes according to order, reason for use and resident's response to treatment. Post the Oxygen sign and explain to the resident, his/her roommate and all visitors the regulations regarding the use of smoking materials near oxygen.Record the oxygen use in the resident medical record.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 1 resident (Resident #5) reviewed for dialysis.- The facility failed to ensure Resident #5 had a physician's order for hemodialysis (machine filters the blood when kidneys do not work) on 9/26/25, when he went to dialysis 3 x week on Tuesday, Thursday, and Saturday.This failure could place residents at risk of complications of hemodialysis, not receiving proper care and/or treatment, and missed treatments.The findings included:Record review of Resident #5's undated face sheet revealed he was an [AGE] year-old male admitted on [DATE] with diagnoses of heart failure (heart does not pump effectively), seizures, and chronic kidney disease (kidneys do not filter). Resident #5's MDS assessment had not been completed yet.Record review of Resident #5's Baseline Care Plan dated 9/20/25 by the DON, revealed a diagnosis of dependence on renal dialysis but there was no mention of the resident receiving dialysis as part of the Care Plan.Record review of Resident #5's previous hospital records dated 9/15/25 at 7:16am by MD K, revealed the resident had ESRD (kidneys do not work) and was on HD (dialysis) TTS (Tuesday, Thursday, Saturday). He had a LUE fistula [dialysis access] with good thrill and bruit [the feeling of blood rushing through the access].Record review of Resident #5's admission assessment dated [DATE] at 5:04am by LVN E, revealed the resident was receiving dialysis. Record review of Resident #5's admission summary dated [DATE] at 7:47pm by an unknown nurse, revealed he received dialysis three times a week.Record review of Resident #5's Dialysis Communication Form dated 9/20/25, revealed he had dialysis from 11:18am-12:25pm and 1.5L of fluid was removed from his body via his LUA AVF (dialysis access).Record review of Resident #5's Physician Orders by MD B, reviewed on 9/26/25, revealed no orders for dialysis.In an interview and observation on 9/26/25 at 9:59am, Resident #5 was sitting up in bed with family present. The resident had a LUA fistula present. The resident's family member said she had concerns about his dialysis bandage not being changed when he got back.In an interview on 9/26/25 at 12:40pm, RN A said he knew a resident was on dialysis because the resident would tell him themselves, or the off going nurse would tell him in report. He said there should also be an order for the dialysis that would specify the days and the facility the resident went to. RN A said if there was not an order for dialysis, someone who was not familiar with the resident would not know they were on dialysis.In an interview on 9/26/25 at 4:25pm, the DON said if there was not an order in the resident's chart it could cause harm, or the resident could miss treatment.Record review of the facility's policy and procedure on Hemodialysis, Care of Residents (Updated August 2017) read in part: The facility provides residents with safe, accurate, and appropriate care, assessments and interventions to improve resident outcomes.Review and ensure orders upon admission are received for follow-up dialysis center appointments, shunt care, diet and fluid restriction (physician discretionary). Place a colored armband that indicates No BP this Arm on the Resident's arm that has the shunt.Provide routine AV Shunt Care and Monitoring per physician order and/or facility policy. Check vital signs upon arrival post-dialysis according to physician's order. Do not take blood pressure on arm with dialysis shunt.Check graft site for bleeding every 4 hours or twice during the shift after which the resident returns, or per physician's order.Monitor lab work. Notify physician as ordered or when lab values are abnormal.Record review of the facility's policy and procedure on Physician's Services (Updated June 2022) read in part: It is the facility's policy to ensure that its residents are provided with an attending physician that will supervise and direct its medical care. The medical supervision of the care of each resident by a physician will include orders for immediate need and care throughout resident's stay. The physician supervises the medical care of residents by means of participating in the resident's. assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment when contacted by the facility. It also includes, but is not limited to, prescribing medications and therapy.Physician Visits. During physicians' visit, the attending physician will: Review the resident's total program of care, including medications and treatments, at each visit; Physician visits will include an evaluation of the resident's condition and total program of care, including medications and treatments, and a decision about the continued appropriateness of the resident's current medical regimen.Write, sign, and date progress notes at each visit as well as sign and date all orders. During visits, the physician will also sign and date all orders.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 7 residents (Resident #1) reviewed for infection control. - RN N failed to wear a gown during incontinence care on 9/26/25, when Resident #1 was on EBP.- RN N failed to change her gloves during incontinence care on 9/26/25, after removing the dirty brief and putting a clean one on for Resident #1.- RN N failed to clean Resident #1's suprapubic catheter (a tube inserted into the abdomen and directly into the bladder to drain urine) away from the insertion site and instead cleaned towards the insertion site on 9/26/25. These failures could place residents at risk for infection, cross contamination, and hospitalizations. Findings included: Record review of Resident #1's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE]. There were no diagnoses listed on the face sheet.Resident #1's MDS assessment had not been completed yet.Record review of Resident #1's Baseline Care Plan dated 9/24/25 by RN P, revealed he was receiving antibiotic therapy and had a urinary catheter.Record review of Resident #1's previous hospital records dated 9/23/25 at 1:49pm by MD O, revealed the resident was being treated for an acute CVA (stroke) and a UTI (urinary infection). He had diagnoses of neurogenic bladder (bladder does not function properly due to damaged nerves) with a suprapubic catheter.Record review of Resident #1's admission summary dated [DATE] at 4:10pm by RN P, revealed the resident had a Mid lower suprapubic catheter 14 fr 10cc inflated.Guest is on antibiotics Cefepime [type of antibiotic] 1 gram in 500 ml (1gram into venous catheter every 8 hrs.).Record review of Resident #1's admission assessment dated [DATE] at 4:37pm by RN P, revealed he had diagnoses of AMS (confused) after a fall, CVA, HTN (high blood pressure), AKI (kidneys not working properly), Parkinson's, and afib (irregular heart rate). It also revealed the resident had a suprapubic catheter and was on antibiotic therapy. The assessment revealed the resident was totally dependent on staff for physical function and required 1-person physical assistance. The assessment revealed the resident had an IV, and he had left side weakness with right side facial droop.Record review of Resident #1's Progress Notes dated 9/26/25 at 4:32am by LVN H, revealed the resident was on Cefepime 1gm TID through his R AC (right elbow) midline for Pseudomonas UTI.Record review of Resident #1's Physician Orders revealed the following orders from MD B:- Enhanced Barrier Precautions: Wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line [long, thin tube inserted into large vein], urinary catheter, feeding tube, tracheostomy), wound care (any skin opening requiring a dressing), every shift for indwelling medical devices, wound, MDRO (antibiotic resistant bacteria) (current or HX of), suprapubic catheter mid lower abdomen, IV midline (type of IV inserted into larger vein). Ordered on 9/24/25 at 4:15pm.- Cefepime HCl Solution 1 GM/50ml, 1gm IV TID for infection-UTI Pseudomonas (type of bacteria) until 9/29/25, via R AC Midline. Ordered 9/25/25 at 2:03am.- Indwelling Suprapubic Catheter 14 Fr with 10 cc bulb connect to straight drainage. Notify MD as needed for non-patency of S/P catheter, every shift for neurogenic bladder and obstructive uropathy (urine flow is blocked in the urinary tract). Ordered on 9/25/25 at 11:56pm.In an interview and observation on 9/26/25 at 10:31am, Resident #1 had a midline to his R AC attached to an IV line that was hanging on a pole next to his bed. The IV bag was for Cefepime. He also had a foley bag hanging to the left side of the bed. The resident said his bottom hurt and wanted to change positions.In an interview and observation on 9/26/25 at 10:36am, RN N provided incontinent care to Resident #1 without wearing a gown when Resident #1 was on EBP. RN N opened Resident #1's brief while he was lying on his back and wiped between his legs with 1 wipe several times. Without changing gloves or sanitizing, she then got a new wipe and cleaned Resident #1's genitals with the same wipe several times. Then RN N turned the resident to his side and wiped some feces off his bottom, without sanitizing or changing her gloves. RN N proceeded to put a clean brief on the resident without sanitizing her hands and changing her gloves and then turned him back on his back. She continued to clean his suprapubic catheter (without sanitizing her hands and changing gloves) from outwards towards the abdomen. She did this several times with the same wipe. When she was finished, she put the resident's bedding back on him with the same dirty gloves.In an interview on 9/26/25 at 10:47am, RN N said EBP was for any openings like IVs, wounds, or tracheostomies (hole in the neck for breathing tube). She said for a