

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 11/28/2025
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)		
F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. (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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to promptly provide lab results outside of clinical reference ranges to the ordering practitioner for 1 (CR# 1) of 8 residents reviewed for lab services. The facility failed to report a critical Glucose level of 42 to the physician when CR #1 had a change in condition on 11/24/25. CR# 1 was pronounced deceased at the facility on 11/25/25 by EMS. An Immediate Jeopardy (IJ) was identified on 11/26/25. The IJ template was provided to the facility on [DATE] at 4:06 p.m. While the IJ was removed on 11/28/25, 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's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of delay in care, worsening of health conditions, adverse reactions, hospitalization, and death. Findings included: Record review of CR #1's undated face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of malignant neoplasm (cancerous tumor) of lower-inner quadrant of left female breast, secondary and unspecified malignant neoplasm of axilla (the space below the shoulder through which vessels and nerves enter and leave the upper arm) and upper limb lymph nodes, secondary neoplasm of bone, secondary neoplasm of unspecified adrenal gland, anemia (a condition of not having enough healthy red blood cells to carry oxygen to the body's tissues) in neoplastic disease, chronic combined systolic (congestive) and diastolic (congestive) heart failure, and acute kidney failure (rapid loss of the kidney's ability to remove waste). Further review of CR #1's face sheet under Advanced Directive indicated she was full code. Record review of CR #1's MDS dated [DATE] indicated she had a BIMS score of 15 indicating cognition was intact. Record review of CR #1's orders with a start date of 11/16/25 indicated vital signs to be taken every shift. Record review of CR#1's baseline care plan dated 11/6/25 revealed she needed nursing services for the following: wound management, pain management, laboratory testing, dialysis treatment, oncology, and physician services-other specialty/clinic follow-up appointment. Record review of CR #1's care plan dated 11/16/25 indicated she needed hemodialysis r/t ESRD. Interventions included: check and change dressing daily at access site, document. Do not draw blood or take B/P in arm with graft. Monitor labs and report to doctor as needed. Monitor vital signs/labs. Notify MD of significant abnormalities. The client is at risk of abnormal vital signs and labs r/t current diagnosis and conditions. Record review of progress note dated 11/24/25 at 8:00 pm entered by LVN B, read, late entry: guest was clean and dry at this time. Hands are cold to touch and O2 could not be obtained at this time. Guest responding verbally to baseline. Record review of progress notes dated 11/24/25 9:30pm by LVN B documented O2 obtained at this time. Hands are warm to the touch. Pulse oximetry measures 94% on RA. Record review of progress notes dated 11/25/25 12:54 am by LVN B documented Spoke with representative from Clinical Lab. Blood glucose measured 42. Blood was drawn at dialysis between 1:00pm-2:00pm. MD notified. Record review of the Lab Results Report dated 11/25/25 indicated a low critical glucose value of 42. During a telephone interview with the Family Member on 11/25/25 at 12:33 pm, the Family Member said a family friend was there to visit CR #1 around 8:00 pm on 11/24/25 and the family friend told her CR #1 was fine. The Family Member said RN A told her the last set of vitals for CR #1 were taken at 10:30 pm on 11/24/25. During a telephone interview with CNA B on 11/25/25 at 12:49 PM, she said she checked on CR #1 between 5:45 am to 5:50 am on 11/25/25. CNA B said she went into CR #1's room and told her I'm going to check on you before I leave. CR #1 responded to CNA B softly mmm, ok. CNA B said the last set of vitals for CR #1 were done around 10:00 pm on 11/24/25. CNA B said she had a hard time getting an O2 reading because CR #1's hands were extremely cold. CNA B said she reported this to LVN B. CNA B said she and LVN B even tried to take an O2 reading from CR #1's toes and that did not work. CNA B said LVN B went in about 30 minutes later and was able to take the O2 reading. During a telephone interview with LVN B on 11/25/25 at 12:59 PM, she said the last time she saw CR #1 was at 5:00 AM (11/25/25). LVN B said she peeked into the room and saw that CR #1 was sleeping, no vitals were taken at that time. LVN B said she the night before on 11/24/25, she and CNA B had trouble getting an O2 reading for CR #1. LVN B said she waited and came back later and was able to get a reading, she said the O2 reading was above 92. LVN B said the chest x-ray was done last night on 11/25/25 between 1:45 am and 2:45 am, she could not remember the exact time. During an interview with CNA A on 11/25/25 at 10:54 AM, she said during shift change this morning (11/25/25) CNA B told her all residents in the 600 hall were checked at approximately 4:00 am and</p>		