| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676436 | A. Building<br>B. Wing | 02/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Thrive Rehabilitation of Pearland | 3406 Business Center Drive<br>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.

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents with pressure ulcers receive necessary treatments and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (CR #1) of 5 residents reviewed for wound care. The facility failed to ensure that CR#1, who was identified as being at risk for pressure ulcer development, received necessary preventative interventions to maintain skin integrity. CR#1 was admitted to the facility on [DATE] with skin intact but was an identified risk for pressure ulcers. On 02/02/26, CR#1 was placed in her comfort chair at 1:10 p.m. and remained there until the morning of 02/03/26 at an unknown time. CNA A observed an open dark purple wound on CR #1's sacrum at 6:15 a.m. while providing peri care on 02/03/26. On 02/04/26, The ADON identified the red open sore of CR#1's sacrum as a stage 2 pressure ulcer. These failures could place residents at risk for worsening skin break down, progression of the ulcer to more severe stages, and overall decline in quality of life Findings Include:Record review of CR #1's facesheet revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were dementia, senile degeneration of the brain (progressive decline of the brain), heart failure, encounter for palliative care (care that provides symptom relief, comfort, and support to people living with serious or chronic illness), body mass index 19.9 or less, bed confined, and a need for assistance with personal care. She was discharged on 02/07/26. Record review of CR #1's baseline care plan initiated 02/01/26 revealed the resident was to receive respite care and facility would maintain comfort related to hospice status until she returned to the community. Record review of CR#1's admission assessment under section J titled Integumentary System and Braden Skin Risk Score completed by LVN A on 02/01/26 revealed that CR#1's sensory perception was very limited, skin was occasionally moist, she was bedfast, friction and shear were a potential problem, and her mobility was very limited. Skin was documented as good/intact and no skin issues were identified. Under section G: Physical function, CR#1 was a 2 person assist with transfers and a one person assist with bed mobility. She also required total dependence of staff for locomotion, transfer, and bed mobility. Record review of CR#1's Braden Skin Assessments (tool used to assess the risk of developing pressure injuries, guiding preventative care) revealed one assessment was completed on 02/05/26 by the WCN. The assessment revealed that CR#1 had a very limited response to pressure related discomfort, she was bedfast, she had very limited ability to change and control her body position, had adequate nutrition, and had a potential problem of friction and shear. Scoring for this assessment ranged from 6-23. CR#1's Braden Skin assessment revealed a score of 13, meaning moderate risk for developing pressure ulcers. No admissions skin assessment was found in the assessments. Record review of CR#1's BIMS Assessment (assessment used to assess resident's cognitive function) revealed a score of 0 (severe impairment). Record review of CR#1 Nursing Order Note from the HRN revealed on 02/02/26 that CR#1 needed to be placed in a chair with arms several times daily and nystatin powder<br><br>(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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (used to treat fungal infection of the skin) should be used after each change. Record review of CR#1's progress notes revealed on 02/04/26 at 4:56 p.m. by the ADON revealed: This writer was called into the guest's room. Nurse aides reported an area on the guest's back. Noted an open abrasion lower mid coccyx, wound has crater but has dry tissue present in the wound bed. Zero drainage, no edema (swelling In the legs due to fluid buildup), no erythema (superficial reddening) to the surrounding skin. Area cleansed with moistened gauze, Zinc paste applied and top with Bordered gauze. Showed no s/s of pain and discomfort. Resting well. Staff placed her on her side with pillow tucked to the side for pressure relief measures. Calls made to Hospice to update the assigned nurse of new skin area. Record review of CR#1's skin observation tool completed on 02/04/26 by the ADON revealed an open abrasion on her lower coccyx. The wound bed was dry, no active drainage, and the wound had a crater with depth. Measurements were 2.2 x 1.4 cm and 0.2 depth. Record review of CR#1's orders revealed that wound care was initiated on 02/04/26. Orders revealed to cleanse the wound on mid lower coccyx (bone of the pelvis) with moistened gauze, apply zinc paste, top with bordered gauze daily, and a prn order was entered for dislodgement. On 02/05/26, a low air mattress was ordered, and CR#1 was ordered to start Vitamin C oral tablet and amino acids oral liquid. Record review of CR#1's skin observation tool completed on 02/06/26 by the ADON revealed a new coccyx wound found on 02/04/26 and reassessed on 02/06/26 with worsening, surrounding skin discolored, red/purple around entire lower buttocks, and the left butt cheek macerated (softened by soaking in liquid). The HRN updated. Record review of CR#1's care plan revealed that the care plan was closed from view until 02/06/26 (original admission [DATE] for periodic respite care services) and reopened by the ADON. The care plan was updated on 02/06/26 to include wound prevention. CR#1's care plan revealed that CR#1 had a stage 2 pressure ulcer on her sacrum r/t disease process hospice, diagnosis dementia, history of ulcers, and immobility. Interventions listed to avoid positioning the resident on sacrum. Record review of CR#1's Kardex tool (reference for essential patient information) for CNAs revealed to avoid positioning the resident on her sacrum and to follow the facility policies/protocols for the prevention/treatment of skin breakdown. Record review of CR#1's POC Response History for Task Chair/bed to chair transfer revealed on 02/02/26 at 1:10 p.m., CR#1 was transferred by CNA A and required partial/moderate assistance. On 02/03/26 at 1:10 am, CNA B documented an independent transfer, described as a transfer completed by CR#1 with no assistance from a helper. In an interview on 02/18/26 at 11:38 a.m., CR#1's FM stated that on 02/02/26, CR#1 was left in her chair overnight. She stated that CR#1 was last seen in the comfort chair in her room by FM2 around 6 p.m. When CNA A returned to work on the 6 a.m. to 6 p.m. shift on 02/03/26, CR #1 was sitting in the comfort chair where she had placed her during her 6 a.m. to 6 p.m. on 02/02/26. The FM stated herself and the HRN was informed by the ADON that CR#1 developed a stage 2 pressure ulcer on 02/04/26. The HRN was very mad because she did not have skin issues when she was admitted . She explained CR#1 to be very laid back and not combative. She stated that if CR#1 was left in the chair all night and said no when she was asked to get into bed, it was evident that staff did not come back around to ask again if she wanted to get into bed. In an interview on 02/18/26 at 11:47 a.m. with the HRN, he stated that he was CR#1's nurse and he had worked with CR#1 and her family for several months. On Monday 02/02/26, HRN spoke with CR#1's floor nurse and explained to him what needed to be done. He ordered for CR#1 to be moved from the bed to the chair several times a day so that she didn't get bed sores and they assisted her in the chair while the HRN was on site. When the HRN returned to the facility around 10:30 a.m. on 02/03/26, he stated that CR#1 was in bed and it took him 10 to 15 minutes to arouse her awake which was uncharacteristic of her. When she woke up, she looked exhausted and like she had been through the ringer. He asked CNA A if anything<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | was wrong with CR#1, and CNA A stated that she found her in the chair that morning when she began her shift. The HRN stated that he had been taking clients at this facility for many years and he knew that staff did not wake residents up and take them out of bed very early in the morning. When the HRN informed the ADON that CR#1 had been left in the chair overnight, the first thing the ADON said was Who told you that?. The ADON told the HRN that when she asked CNA B why CR#1 was left in the chair overnight, that CNA B stated CR#1 refused to get out of the chair. The HRN stated that CR#1 was the easiest person to take care of and she would not have refused to do anything. He stated that if the nurse on the 6 p.m. shift would have been doing her rounds the night of 02/02/26, she would have seen her in the chair and CR#1 refusing care was an excuse. The HRN stated [CR#1] is senile, 94lbs, and 91 years. Are you a nurse or a doormat. Instead, CR#1 had to sleep in a hard plastic chair with plastic arms. He explained that the second to last time she stayed at the facility for respite care (November 2025), she developed a stage 1 pressure ulcer to her sacrum. She normally would stay for respite care at the facility for 3-4 days, but her last admission [DATE]- 02/07/26) was her longest stay. HRN stated that CR#1 had a stage 2 pressure ulcer that he measured at 1.5 x 1.5 cm. The HRN stated that he tried to obtain an air mattress from the hospice company but they told him no because CR#1 did not currently have a pressure ulcer. At the facility, he asked the ADON two times if CR#1 could have an air mattress and she told him no because she didn't have any pressure ulcers, although he informed her that she developed a wound prior to this admission. The HRN explained that he received a call on 02/03/26 that CR#1 had developed a pressure ulcer and on 02/04/26, they created treatment orders. When informed of the wound, the HRN did not complete a full body head to toe assessment but he checked her from the waist up. He explained that because she was acting out of character that morning, he was more so focused on her mental state and that is why he didn't do a head-to-toe assessment. In an interview on 02/18/26 at 12:11 p.m. CNA A stated that she worked Hall A on 02/02/26 from 6 a.m. to 6 p.m. She stated that when she spoke with the HRN, he told her that CR#1 liked to get up in the comfort chair and sit up. She told him okay and she sat her in the chair around 3pm. Before she left her shift at 6 p.m. she let her relief, CNA B, know that CR#1 was currently in her chair and she left. When CNA A returned to the facility on [DATE] at 6:15 a.m., she saw CR#1 in her chair and she was wearing the same clothes as the day before so she assumed that she had been in her chair overnight. Usually during shift changes, aides were supposed to disclose what happened during their shift, but she did not receive any new updates from CNA B. Once found in the chair, CNA A changed CR#1 and put her back into bed. She explained CR#1 to be easy to redirect and she was able to communicate sometimes. CNA A stated that when she worked with her on 02/02/26, her skin was discolored but she did not have any wounds on her bottom. On 02/03/26 after she found her in the chair that morning, her bottom had an open, dark purple wound on her sacrum. The ADON was notified and she informed CR#1's HRN. In an interview on 02/18/26 at 1:22 p.m., CNA B stated that she worked from 6 p.m. to 6 a.m. on 02/02/26. She explained that 02/02/26 was the first time she met CR#1. She sat in the comfort chair in her room and CNA B greeted her then continued with rounds. She came back to CR#1's room to attempt to change her (could not recall time) but she was not wet. She tried to talk to CR#1 but she was very sleepy. CNA B stated that when she tried to touch CR#1 she would lean back but she did not verbalize or say anything to her. She stated that she refused so she left her seated in the chair. During CNA B's last round around 4am, CR#1 was still sleeping in the chair. She could not recall if she changed her in the bed or the chair, but she said she made sure CR#1 was clean before she left and stated, I probably left her in the chair instead of getting her in the bed, but she was comfortable in that chair and it wasn't a dangerous situation. CNA B attempted to recall the sore on CR#1's<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | bottom during peri care and stated that she thought the sore on her bottom was old because she had been doing this (CNA work) for a while. She stated that she did not review CR#1's medical history or her admitting paperwork so she could confirm the sore was old. When asked to describe how the wound looked, she responded that it was an open sore. CNA B denied informing LVN B, the ADON, DON or the oncoming aide, CNA B stated CR#1 had refused to get out of the chair or that there was a sore on her bottom. She could not state why she did not inform any other staff regarding the sore. In an interview on 02/18/26 at 1:06 p.m., RN A stated that she worked on 02/02/26 from 6 p.m.- 6 a.m. Her responsibilities as a night nurse included rounding on patients every 2 hours, patient care, and medication administration. She recalled that CR#1 was at the facility for respite care and she first saw her that night around 6pm. She stated that she was supposed to round every 2 hours with residents and when she saw CR#1 at 6 a.m., she stated that she thought she saw her in bed, but she could not confirm that. In an interview on 12/18/26 at 2:12 p.m., the ADON stated the DON was currently on personal leave. The ADON first met CR#1 on 02/02/26 and she could not remember if she changed her or an aide changed her, but she saw old scar tissue on her bottom. She described the scar tissue as dry skin located in the mid center of the sacrum and could not say why evidence of a pervious scar was not mentioned during the admission assessments. The ADON stated that the HRN informed the ADON and CNA A to not keep CR#1 in the bed and always put her in the recliner. The ADON reviewed the order that was written by the HRN and read aloud that the order said to place CR#1 in the comfort chair several times a day and she stated that the order could have been misinterpreted by staff to mean let CR#1 sleep in the chair. The ADON stated that CR#1 did not weigh a lot so sitting on anything for too long could be bad. The ADON stated that if a patient had poor mobility, was on morphine, and had impaired tissue perfusion, they could be at risk for developing skin issues, but not checking on CR#1 did not help. She explained that the care plan was not opened during admission because some staff members may have been intimidated by opening documents and that was something she would need to reeducate nurses on. The ADON stated her expectations of the night shift staff were to complete frequent rounds and make sure residents were turned and repositioned. In an interview on 12/18/26 at 3:16 p.m., CR#1's FM2 stated that she visited CR#1 in the facility on 02/02/26 at 5 p.m. and she was in the comfort chair inside her room. Record review of the facility's policy titled: Skin Breakdown, Prevention, and Management revised March 2017 documented that it was the goal of the nursing staff with the assistance of the IDT team (interdisciplinary team) using the nursing process to identify, assess, plan, prevent, intervene, and monitor progress of care for all residents at risk for developing and or developed any type of pressure or no pressure skin discoloration or breakdown.PURPOSE:To identify the presence of any pressure or non-pressure skin discoloration and/or breakdown.To identify the residents at risk for developing pressure ulcers, the level and nature of riskTo provide practice guidelines for assessment, prevention, intervention andmonitoring of pressure and non-pressure skin discoloration and/or breakdown.To ensure that all causes of pressure or non-pressure skin discoloration and/or breakdown are investigated and documented in a timely, thorough mannerPROCEDURE:1. Upon admission, all residents will receive an initial skin and risk assessment.a. A skin assessment will be completed upon admission for all resident, which will include pressure and non-pressure skin discoloration and/or any type of skin breakdown.b. A description of the residents' skin condition will be included in the nursing documentation upon admission and every shift for seventy-two (72} hours thereafter.c. The resident's risk for developing pressure ulcer will be assessed using the Braden Scale Skin Risk Assessment. The Braden Scale Skin Risk Assessment will be completed upon admission, weekly for four (4} weeks thereafter, quarterly thereafter and with any significant change of condition as defined<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | by the RAI Manual. 2. The licensed nurse assigned to a resident who is identified to be at risk for developing pressure ulcer will initiate preventive measures. Preventive measures will be updated as often as the Braden Scale skin risk assessment is completed based on supported clinical practice guidelines. 3. Upon admission and when a resident is identified to have a pressure ulcer, non-pressure skin discoloration and/or skin breakdown, the licensed nurse will contact the attending independent licensed practitioner for any sites or area that requires any form of treatment.a. The licensed nurse assigned to the resident will assess, evaluate and initiate a change of condition nursing documentation to last for at least seventy-two (72) hours every shift.4. A Weekly Skin Condition Documentation Form will be initiated and completed for any non-pressure skin discoloration and/or skin breakdown. A weekly assessment will be completed until the non-pressure skin, discoloration and/or skin breakdown is resolved.5. An individualized care plan will be developed for residents at risk of developing! pressure ulcers and/or presence pressure and non-pressure skin discoloration ' and/or breakdown.a. An admission care plan for prevention must be developed within 24 hours of admission for residents with a Braden score of 8 or above.b. A comprehensive care plan pressure and non-pressure skin discoloration and/or breakdown will include pressure relieving devices, turning and appropriate positioning, incontinence management, and protection of the skin from moisture, nutrition and fluid intake.c. Care plan interventions for treatment of open skin, whether pressure or non-pressure skin discoloration and/or breakdown should include the treatment prescribed by the independent licensed practitioner and infection control precautions, if any. The care plan should also include the following interventions:a. Resident Choiceb. Advance Directivec. Repositioningd. Nutritional Interventione. Treatmentf. Support Surfaces and Pressure Redistribution |