

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  01/31/2025
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)
<p>F 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722</b></p> <p>Based on interview and record review the facility failed to not employee and individual that was found guilty of mistreatment in a court of law for 1 of 12 employees reviewed (Med Aide G).</p> <p>The facility failed to perform an accurate criminal history background check on Med Aide G and allowed her to work at the facility for about 11 months, while she had a conviction that was an absolute bar to employment.</p> <p>This failure could place residents at risk for mistreatment.</p> <p>Finding included:</p> <p>Record review of the State of Texas, Health and Safety Code, Chapter 250, Section 250.006 Convictions Barring Employment revealed (Revision 24-1, Effective [DATE]): A person for whom the facility or the individual employer is entitled to obtain criminal history record information may not be employed in a facility or by an individual employer if the person has been convicted of an offense listed in this subsection: .an offense under Section 22.02, Penal Code, aggravated assault [violent crime that involves causing serious bodily harm to another person or using a deadly weapon] .</p> <p>Record review of the employee files for Med Aide G revealed she was hired on 2/2/24. Record review revealed her initial criminal history check was done on 2/2/24 and indicated she was convicted of aggravated assault on 4/16/2016, which was a complete barrable conviction.</p> <p>In an interview with the Administrator on 1/30/25 at 8:26am, she said Med Aide G worked from 6am to 6pm. She said Med Aide G had never had any complaints and had not received any allegations of abuse, neglect, or misappropriation. The Administrator said she thought the absolute barrable conditions were felonies, abuse, and murder. She said she did not think aggravated assault was a barring condition unless it was a felony. She said the employee had been working at the facility for almost a year and had worked at other facilities as well. She said if an employee continued to work with a barring condition it could put the residents at risk.</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 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Administrator and COO on 1/30/25 at 9:00am, they had printed out the list of barring conditions and asked to clarify where it said aggravated assault was one of the conditions. The Surveyor showed them toward the top of the list it said, aggravated assault. They were looking further down the list where it said assault and that was a barring condition for 5 years. The Administrator and COO confirmed that was correct and said they would let Med Aide G go, even though they really did not want to.</p> <p>In an interview with the Administrator on 1/30/25 at 11:05am, she said she completed an audit of all the criminal history background checks and there were no other issues/concerns.</p> <p>Record review of the facility's policy and procedure on Employee Screening - Texas (Revised August 2023) read in part: This policy establishes the background screening requirements for all prospective and current employees to ensure compliance with federal and Texas State regulations, protect the safety of clients and staff, and uphold the integrity of the organization. The Administrator is responsible for implementation of policy and procedures. Background Check Requirements: Pre-Employment Screening. All job applicants must undergo a background check before receiving an official job offer. This includes: Criminal History Check - A review of Texas Department of Public Safety (DPS) records and national databases . Disqualification Criteria. Applicants or employees may be disqualified from employment if they have: Convictions or other serious offenses as outlined in the Texas Occupations Code .</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863</b></p> <p>Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided accurate Preadmission Screening and Resident Review (PASRR) screening for 1 (Resident #4) of 5 residents reviewed for resident assessments.</p> <p>The facility did not correctly identify Resident #4 as having a mental disorder on their PASRR Level 1 Screening.</p> <p>This failure could place residents with mental disorders at risk of not receiving specialized PASRR service which could contribute to a decline in physical, mental, psychosocial well-being, and quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #4's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia (loss of cognitive functioning-thinking, remembering, and reasoning), bipolar disorder (A serious mental illness characterized by extreme mood swings), and major depressive disorder.</p> <p>Record review of the PASRR level 1 screening dated 11/02/23 indicated Resident #4 was negative for mental illness, intellectual disability, and developmental disability.</p> <p>Record review of Resident #4's annual MDS, dated [DATE], indicated Resident #4 had a BIMS summary score of 8, which indicated moderate cognitive impairment. Resident #4 had active diagnoses of bipolar disorder and major depressive disorder and was taking an antidepressant.</p> <p>Record review of Resident #4's physician orders dated 01/10/2025 indicated Resident #4 was prescribed Venlafaxine HCl Oral Tablet 37.5 MG (Venlafaxine HCl ) Give 1 tablet via G-Tube one time a day related to major depressive disorder.</p> <p>Record review of Resident #4's care plan indicated Resident #4 uses antidepressant medication related to Depression. Interventions included: Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Trazodone, Remeron. Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. Monitor/document/report to medical doctor prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance.</p> <p>Interview on 01/31/25 at 11:23 am the MDS Coordinator said she was responsible for reviewing the PASRR forms. She said she did not review the PASRR for Resident #4. She said she used the information that she received from the previous nursing facility. She said she would update the PASRR and notify the state today. The MDS Coordinator said the risk to the resident was that she would not get the treatment she needed.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 1/31/25 at 4:18 PM the Administrator said the residents with a mental disorder should be identified on the PASRR 1 and referred to the local authority. She said the risk to the resident was they would not get the services they needed.</p> <p>Record review of the facility's Pre-admission Screening and Resident Review (PASRR) dated December 2022, revealed in part .B. PASRR level Evaluation: a. If the PASRR Level I screening identifies potential serious mental illness (SMI), intellectual disability (ID), or developmental disability (DD), a level II evaluation must be completed before admission .</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45581</p> <p>Based on interviews and record review, the facility failed to develop and complete a baseline care within 48 hours of a resident's admission for 3 of 25 residents (Resident #18, Resident #24, and Resident #126) reviewed for baseline care plan .</p> <p>The facility failed to complete a baseline care plan within 48 hours of admission for Resident #18, Resident #24, and Resident #126</p> <p>This failure could affect newly admitted residents and place them at risk of not receiving continuity of care and communication among nursing home staff to ensure their immediate care needs were met.</p> <p>Findings included:</p> <p>Record review of Resident #18's Face Sheet noted the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with primary diagnoses of hemiplegia (a condition characterized by paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction affecting left non-dominant side.</p> <p>Record review of Discharge MDS dated [DATE] did not indicate a BIMS score. Assessment of mental status indicated the resident had a memory problem with some difficulty in new situations, no psychosis noted, and occasionally incontinent.</p> <p>Record review of Resident #18's Baseline Care Plan revealed it was completed on and dated 12/18/24, by the DON.</p> <p>Record review of Resident #24's Face Sheet undated noted the resident was an [AGE] year-old female who was admitted to the facility on [DATE] with primary diagnosis encounter for surgical aftercare following surgery on the circulatory system.</p> <p>Record review of Resident #24's Discharge MDS dated [DATE] did not indicate a BIMS score. Assessment of mental status indicated the resident's short-term memory was ok and independently made decisions regarding tasks of daily life. Her functional abilities needed setup or clean up assistance for sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, car transfer, walk 50 feet with two turns, and walking 150 feet.</p> <p>Record review of Resident #24's Baseline Care Plan revealed it was completed on and dated 11/19/2024, by the DON.</p> <p>Record review of Resident #126's Face Sheet undated noted the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #126 had diagnoses of spinal stenosis, lumbar region without neurogenic claudication (narrowing of the lumbar spinal canal that compresses the nerve rootlets and nerve roots).</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #126's Initial MDS dated [DATE] noted a BIMS score of 12 indicating moderate cognitive impairment. The resident used a walker for mobility and needed supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with toileting hygiene, shower/bath self, upper body dressing and personal hygiene, and dependent on lower body dressing and putting on/taking off footwear.</p> <p>Record review of Resident #126's Baseline Care Plan revealed it was completed on and dated 01/21/2025, by the DON.</p> <p>In an interview on 01/30/2025 at 11:00AM the MDS Nurse said for the Base Line Care Plan, the admission nurse opened the Care Plan tab in the system and the admitting nurse did the assessment. That information was transferred from that assessment into the Care Plan and information from the admission assessment was transferred to the Baseline Care plan form. She said the Base Line Care Plan was written within 48 hours of admission. She said the Base line Care Plan was complete when the nurse signed it. She said the DON signed the Base Line Care plans. She said she and the DON were responsible for the Base Line Care Plans. She said the risk to residents was if the policy was not followed, the residents might not get the care they needed.</p> <p>In an interview on 01/30/2025 at 11:21AM the DON said she signed them, and the nurses started them. She said when she signed the Base Line Care Plan that meant it was complete. She said according to the company, the Base Line Care Plan needed to be complete within 5 days. She reviewed the Base Line Care Plans for Resident #18 and #24. She said Resident #18' Base Line Care Plan was not done within 48 hours. She saw that Resident #24's Base Line Care Plan was not done within 48 hours. She said she did not know why the Base Line Care Plans were done late. She said the risk to residents if policy/procedure were not followed was staff would not know how to properly care for the resident and the worst thing was staff were not able to follow through with things for the resident. She said she last had training on Base Line Care Plans when she first started 8 months ago. She said she was responsible for ensuring policy/procedure were followed.</p> <p>In an interview on 01/30/2025 at 11:34AM the Administrator said the MDS nurse, or the DON wrote the Base Line Care Plans. She said it needed to be an RN. She said the first care plan was done within 48 hours, normally. She said the reason the Base Line Care Plans were not completed in time was she thought it was too much work for the DON to have signed them in time. She had not recently had training on Base Line Care Plans. She said the risk to residents was if policy/procedure were not followed and the Base Line Care Plan was late, the residents potentially would not get the care they needed, and the worst thing to happen to a resident when policy/procedure was not followed was death.</p> <p>Record review of the facility's policy titled, Baseline (Initial) Plan of Care Summary dated December 2016 read in part . Policy: It is the policy of this facility to provide each resident with an interim (initial) plan of care developed within 48 hours of admission that addresses identified risk areas and resident's initial individual needs and baseline summary will be completed before a comprehensive care plan is completed. Purpose: The Baseline (Initial) Plan of Care documents and communicates the resident's needs within 48 hours of admission and until the Comprehensive Plan of Care is finalized by the interdisciplinary team .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722</b></p> <p>Based on observation, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 (Dryer #2 the one in the middle) of 3 dryers reviewed for accident hazards.</p> <p>The facility failed to check and clean the lint filters at appropriate times:</p> <ul style="list-style-type: none"> <li>- The facility failed to clean the lint filter in Dryer #2 for 19hrs, which caused a buildup of lint on the filter, above the filter, and around the filter.</li> </ul> <p>This failure could place residents at risk of harm and hospitalization by causing a fire risk to the facility.</p> <p>Findings included:</p> <p>In an observation on 1/29/25 at 2:45pm, the Maintenance Director pulled out the lint filter for Dryer #1. There was a thick sheet of lint on the filter, as well as lint above where the filter slides into place, and around where the filter was kept. There were no laundry staff anywhere.</p> <p>In an interview with the Maintenance Director on 1/29/25 at 2:57pm, he said staff checked the lint filters twice a day. He said staff must have forgotten to check the filters and that was a hazard to the residents and could cause a fire. The Maintenance Director said he oversaw the laundry room.</p> <p>Record review on 1/29/25 at 2:55pm, of the facility's Lint Trap Cleaning Log for January 2025 revealed spots to sign off every hour indicating the lint trap was cleaned. There were no initials for the whole day and the last initials were from 1/28/25 at 7am.</p> <p>Record review of the facility's policy and procedure on Laundry Equipment (Revised [DATE]) read in part: Laundry equipment is inspected and maintained periodically to ensure proper configuration and operation. Laundry equipment maintenance is an essential function of the preventative maintenance program to assure employee and resident safety .Clean dryer lint traps several times each day to help limit fires, and increase the life of the dryers .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45581</p> <p>Based on interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #126) of 25 residents reviewed for pharmacy services.</p> <ol style="list-style-type: none"> <li>1. The facility failed to administer two doses of Morphine Sulfate Oral Tablet 30 MG (Morphine Sulfate) for Resident #126 to prevent potential pain.</li> <li>2. The facility failed to ensure the nurse's medication cart (500/600hall) did not have discontinued and/or expired medications.</li> </ol> <p>These failure could place residents at risk for adverse effects of pain, discomfort, increase side effects, not receiving the therapeutic effects of the medication, and a decline in health.</p> <p>The findings were:</p> <p>Record review of Resident #126's Admission Record revealed Resident #126 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #126 had diagnoses of spinal stenosis, lumbar region without neurogenic claudication (narrowing of the lumbar spinal canal that compresses the nerve rootlets and nerve roots).</p> <p>Record review of Resident #126's MDS dated [DATE] noted the resident had a BIMS score of 12 indicating some cognitive impairment and had frequent pain. Pain management indicated she needed scheduled pain medication regimen. The pain intensity was rated a 6 of 10. Care Area Assessment indicated she had pain. Resident #126 received scheduled pain medication regimen.</p> <p>Record review of Resident #126's Care Plan, undated read in part .Focus: chronic pain to lower back and left shoulder secondary to myalgia and arthralgia. Goal: The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Interventions: Monitor/record/report to Nurse any s/sx of non-verbal pain. The resident is able to: call for assistance when in pain, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain.</p> <p>Record review of Physician Order Recap Report dated 01/09/2025 - 02/28/2025 read in part . Morphine Sulfate Oral Tablet 30 MG (Morphine Sulfate) Give 1 tablet by mouth two times a day for Pain .Start date 01/10/2025, End date 01/27/2025 . Ordered by the MD.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #126's Medication Administration Record (MAR) dated 01/2025 read in part . The resident had a scheduled medication of Morphine Sulfate Oral Tablet 30 MG (Morphine Sulfate). The MAR noted under Scheduled Start Date/Time, 01/10/2024 at 0800, Medication not available/ordered from pharmacy and on 01/10/2024 at 2000, Other/See Nurse Notes. Morphine Sulfate Oral Tablet 30 MG (Morphine Sulfate), Give 1 tablet by mouth two times a day for Pain -Start Date- 01/10/2025 0800, -D/C Date- 01/27/2025 0937 . 01/10 morning dose noted code 11 meaning medication not available/ordered from pharmacy. 01/10 evening dose noted code 9 meaning Other/See Nurse Notes .</p> <p>Record review of evening Progress Note dated 01/10/2025 noted the resident had no complaints or comments regarding pain .</p> <p>Interview on 01/30/2025 at 5:53PM with Resident #126 said she was not in pain and thought it was Morphine that caused her to throw up when she got to the facility. She said she thought she took the morphine on 1/10. She did not take it a couple of nights ago though. She said she preferred to have the pain patches and did not like taking pills.</p> <p>In an interview on 01/30/2025 at 6:15PM Family Member A said the resident may have told the facility staff she did not want the morphine. She said the only thing she really talked with staff about was the resident's physical therapy.</p> <p>In an interview on 01/30/2025 at 6:22PM LVN B said the pharmacy always runs late and the medications arrive between 10pm and 12AM. She did not know why the nurse that ordered the medication did not get morphine from the e-kit.</p> <p>In an interview on 01/30/2025 at 7:59PM the DON said it seemed like the nurse called the MD for triplicate that morning and it came in that evening. The facility did not have the pain management referral until the resident got to the facility. She said the hospital did not send the prescription. The pain manager doctor came in the next day if he was referred. She said the morphine was ordered on 1/10 at 8AM and it came in that night. She said if the resident was in pain, then the medication could come from the Omni cell, and they could call in for the approval to get the medication for the resident. She said she did not know when the triplicate came in. She said a late medication delivery would be normal and the cut off was at 2pm to have it delivered the same day. She said if a resident came in after 2PM their medications would come in the next night. She said there was morphine in the e-kit. She said she would have to get a code before administering the medication. She said she did not know when the MD was called about the morphine or why the morphine was not pulled from the e-kit, and the resident did not get her medication. She said there was a pain scale on the TAR for the resident. She said if the resident was not in pain, then she did not know why a medication would be given. She did not know why the morphine was a scheduled medication. She said she would clarify the order with the doctor regarding pain medications when the resident was not in pain. She said the morphine was later changed to PRN.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/30/2025 at 6:47pm RN C said she thought the facility had not received the triplicate yet to get Resident #126's Morphine. She said if the triplicate were received then they could administer it. She said when they got the order, she called the MD to get the triplicate. She said she did not know what happened that day and she later got the resident's order to PRN because she said the resident told her she did not want it and it made her very drowsy. She said the resident's vitals were taken each shift. RN C called the pharmacy and asked when they received the triplicate for the resident's morphine. Pharmacy Tech said that the triplicate for the morphine was received at 8:49AM on 01/10/2025. He said the facility signed to receive the medication at 11:26PM on 01/10/2025.</p> <p>Record review of the Omni Inventory for the e-kit indicated the facility had Morphine ER 15mg TAB- 3 tablets, Morphine ER 30mg TAB- 5 tablets, Morphine IR 15mg TAB- 5 tablets, and Morphine Sulfate IR 30mg TAB- 5 tablets.</p> <p>2. During an observation of the 500/600 Hall medication cart on 01/29/25 at 12:20 PM., revealed the following was found:</p> <ul style="list-style-type: none"> <li>-Ipratropium 0.5mg/Albuterol 2.5 mg/3ml box was open and not dated, and the resident had discharged from the facility on 01/27/25.</li> <li>-Trelegy 100/mcg/6.25mcg/25mcg inhaler was opened with an expiration date of 04/2024.</li> <li>-Carbidopa/Levodopa/Entacapone 100 mg tab 1-tab TID had discard after 11/24/24 date.</li> </ul> <p>Interview on 01/30/25 at 11:35 AM, the DON also said that medications should be checked daily by the nurse for expired medications, but she also checked the chart weekly and must have missed the expired meds. She said it was the responsibility of the nurse who used the cart to check for the expired meds. She said the staffing coordinator and the DON conduct checkoff with new nurse hires. The DON said the residents who were discharged from the facility or who have discontinued medications should be pulled from the cart and placed in the destruction bin that day. She said the risk of not removing expired or discontinued meds could be that these medications are accidentally administered. She said the expired or discontinued medications should have been destroyed.</p> <p>Interview 01/30/2025 at 2:07 PM the Administrator said her expectation was not to have expired medications on the cart. She said the DON usually monitored the med carts weekly, but the facility also consulted with the pharmacy staff to review carts and remove all expired meds. She said the ultimate responsibility was the nurse using the cart. She said the nurses were supposed to removed medications the same day the residents are discharged from the facility. The Administrator said the risk of administering expired medication was that it may not have the same potency and/or possibly administering the medications for someone else.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Thrive Rehabilitation of Pearland		STREET ADDRESS, CITY, STATE, ZIP CODE  3406 Business Center Drive Pearland, TX 77584	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Medication Administration policy dated 2017 read in part . Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate. Medications, type of medication and route of administration are administered by authorized personnel according to state regulations .</p> <p>Record review of the facility's Medication Administration and Management policy, revised on 06/2019 read in part, . Security and Safety Guidelines: 19. Outdated medication is destroyed or returned to the pharmacy according to applicable state rules and regulations and a new supply obtained when necessary .</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863</b></p> <p>Based on observation, interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs without adequate indications for its use for 1 of 3 residents (Resident #8) reviewed for unnecessary medications.</p> <p>The facility failed to ensure Resident #8's antibiotic (Bactrim-Sulfamethoxazole/Trimethoprim) was not administered after the discontinued date.</p> <p>This failure could place residents receiving antibiotics at risk for unnecessary and inappropriate antibiotic use and increased antibiotic-resistant infections.</p> <p>Findings included:</p> <p>Record review of Resident #8's face sheet indicated Resident #8 was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses including dementia, peripheral vascular (circulatory condition in which narrowed blood vessels reduce blood flow) disease, and type 2 diabetes mellitus (body has trouble controlling blood sugar).</p> <p>Record review of Resident #8's quarterly MDS assessment, dated 10/30/24, indicated Resident #8 had a BIMS score of 05, which indicated severe cognitive impairment. Resident #8 was dependent and required substantial maximal assistance with most of his functional abilities. The MDS did indicate that Resident #8 had a stage 3 pressure ulcer but had not received an antibiotic in the last 7 days of the assessment period.</p> <p>Record review of a care plan dated 11/18/24 indicated Resident #8 had a risk of complications related to a pressure ulcer located on the right hip that had been resolved.</p> <p>Record review of physician's orders on 01/30/25 at 10: 49 AM indicated that Resident #8 had a discontinued order for Bactrim (Sulfamethoxazole/Trimethoprim) Oral Tablet 800-160mg; give 1-tab by mouth two times a day for his wound for 7 days. The start date was 12/24/24, with an end of 12/31/24. No new Bactrim (Sulfamethoxazole/Trimethoprim) order was noted in the physician's orders .</p> <p>Record review of Resideent #8's December 2024 MAR revealed the last dose of Bactrim (Sulfamethoxazole/Trimethoprim) Oral Tablet 800-160mg was administered on 01/31/24 in the AM. There was no medication administration of Bactrim (Sulfamethoxazole/Trimethoprim) noted on the January 2025 MAR.</p> <p>Observation on 01/30/25 at 10:30AM with LVN A of Resident #8's the right hip wound revealed no wound opening. New foam border dressing applied as ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 01/30/25 at 10:47 AM, revealed LVN E went into Resident #8's room and gave Resident #8 Bactrim (Sulfamethoxazole/Trimethoprim) 1 tab by mouth. The surveyor asked her why the antibiotic was administered and if there was an order. She looked at the physician's orders and said, No, there was no order. She notified the physician and said the physician wanted to continue the antibiotic for 7 days. She denied administering medications without verifying the physician's orders prior to this observation. She said she was supposed to review orders before administering any medications because the orders could change. She said the risk of administering a medication without an order could cause an adverse reaction.</p> <p>Telephone interview on 01/30/25 at 11:02 AM Dr. D, said Resident # 8 was to finish his Bactrim (Sulfamethoxazole/Trimethoprim) treatment in 7 days, which ended on 12/31/24. He said he gave the order to LVN E to restart the Bactrim for 7 days. He said there was no risk to the resident for 1 additional dose of antibiotics. He said ideally, they should complete the prescribed medication, but it was not a big deal if they missed one dose or consumed an additional dose.</p> <p>Interview on 01/30/25 at 11:35 AM the DON said she expected the nursing staff to follow the doctor's orders. She said all discontinued medications should be removed from the cart on the same day they were completed or discontinued. She said the risk of not removing medications from the cart was the staff could accidentally administer a resident's discontinued medication. She said treating a resident with antibiotics without an indication or need could risk certain antibiotics to become ineffective.</p> <p>Interview on 01/30/25 at 2:07 PM the Administrator said it was her expectation to remove completed and/or discontinued medications from the med cart. She said all staff should check the order before administering medications to a resident. She said the risk of administering medications that had no order was an adverse reaction.</p> <p>Record review of the facility's Medication Administration and Management policy, revised on 06/2019 read in part, .Administering the Medication Pass: 3. The authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff member follows the MAR prepared for the patient/resident by identifying the: A. The Right Patient/Resident, B. The Right Drug, C. The Right Dose, D. The Right Time E. The Right Route F. The Right Charting G. The Right Results H. The Right Reason .</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48863</p> <p>Based on observation and interview, the facility failed to ensure all drugs and biologicals used in the facility were secured properly and labeled and stored in accordance with currently accepted professional principles in 1 of 2 medication carts reviewed. (Hall 500/600 cart)</p> <p>The facility failed to ensure the nurse's medication cart (500/600 hall) was locked.</p> <p>This failure could place residents at risk, by placing them at risk of drug diversions, misuse of medications, an adverse reaction, and/or not receiving the therapeutic benefits of their medication.</p> <p>Findings included:</p> <p>During observation on 01/28/25 at 9:32 AM, revealed the nurse medication cart for 500/600 hall was unlocked, with the 2nd drawer slightly ajar. The opened drawer contained multiple daily medications in a blister pack for residents in the 500/600 hall. The nurse was in a resident's room administering their medications, and the cart was left open and unsupervised.</p> <p>Interview on 01/29/25 at 9:38 AM RN C acknowledged that the drawer was unlocked. She said the DON trained her during onboarding regarding the medication carts being locked at all times. She said the cart should have been closed and locked the cart before entering the resident's room to administer medication. She said the risk of leaving the cart open and unsupervised was drug diversion and/or misappropriation by residents, staff, or visitors, which could lead to a sentinel event.</p> <p>Interview on 01/30/25 at 11:35 AM the DON said her expectation was that all medication carts should be locked. She said an in-service was conducted on Tuesday, 01/29/25, regarding locked medication carts. She said the risk of leaving a cart open was that other residents, staff, or anyone else walking down the hall could have access to the medications.</p> <p>Interview 01/30/2025 at 2:07 PM the Administrator said her expectation was that all medication carts should be locked when not in use. She said the risk of not having it locked was that someone could have access to the cart that should not and ingest medication, which caused harm to the residents or staff and/or misappropriation of meds.</p> <p>Record review of the facility's Medication Administration and Management policy, revised on 06/2019 read in part, . Security and Safety Guidelines: 3. Medication cart is kept in sight or locked at all times .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45581</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the kitchen.</p> <p>The facility failed to ensure on 01/28/2028 at 8:15 AM that a cling wrapped bunch of bacon in the refrigerator and cans of thickening agent were labeled and dated with the delivery date.</p> <p>The facility failed to ensure a bag of sausage patties was sealed.</p> <p>These failures had the potential to place residents at risk of serious complications from foodborne illness because of their compromised health status.</p> <p>Findings included:</p> <p>Interview and observation were conducted on 01/28/2025 at 8:15 AM with the acting Dietary Manager and there was a box of sausage patties unsealed. There was also an unlabeled cling wrapped chunk of bacon in the freezer. The acting Dietary Manager said the patties should be sealed and the bacon labeled with the delivery date on it. She then wrote a date of 01/26/2025 on the bacon. She said that was the date the food was delivered, and she knew because she was there when the food came in. The dry goods storage had unlabeled cans of food thickening agent.</p> <p>In an interview on 01/29/2025 at 4:06PM the Dietary Director said he had worked at the facility for 8 months as the Dietary Director. He said as the Dietary Director he planned menus, purchased groceries, wrote the cleaning schedules, gathered logs, scheduled staff, and hire/fired kitchen staff. He said the policy or procedure for storing food was if it was a single item then it was dated with the day of arrival. He said there was already a use before or expiration date. He said if something was not all used then there was a 3-day date placed on the food. He said normally items were wrapped and dated. He said the thickening cans should have been discarded. He said someone did not label after they opened the bag, or maybe they rushed things. He said the risk to residents when policy was not followed was, they could get sick with E. coli or salmonella and the worst thing was death, or food poisoning.</p> <p>Record review of Food Storing Principles policy dated April 2020 read in part . Procedure: 3. Label each package, box, can, etc. with the expiration date, date of receipt, or when the item was stored after preparation .</p> <p>Record review of Cold Food Storage Areas policy April 2020 read in part . 7. Store foods in their original packaging and in leak-proof, nonabsorbent, sanitary containers with tight fitting lids .</p> <p>U.S. Food and Drug Administration Food Code dated 2022 read in part . 3-305.11 (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .</p> <p>(continued on next page)</p>

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F 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	TAC Ch. 228 Subchapter A read in part . (a) The purpose of this chapter is to implement Texas Health and Safety Code, Chapter 437, Regulation of Food Service Establishments, Retail Food Stores, Mobile Food Units, and Roadside Food Vendors. (b) The department adopts by reference the U.S. Food and Drug Administration (FDA) Food Code 2017 (Food Code) and the Supplement to the 2017 Food Code. (c)		

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<p>F 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>45581</p> <p>Based on observation, interviews, and record review, the facility failed to dispose of garbage and refuse properly for 1 of 2 waste receptacles reviewed for garbage disposal.</p> <p>The left dumpster had its top right lid opened when no one was disposing of trash.</p> <p>These failures could place residents at risk for exposure to germs and diseases carried by vermin and rodents.</p> <p>Findings included:</p> <p>Observation and interview with the [NAME] on 01/28/2025 at 10:33AM revealed the dumpster on the left had the top right lid open. She said the lid should be closed and the cleaning people were just there and probably could not reach the lid to close it. The waste receptacle was located on facility property about 30 yards from the building. The closest entrance to the facility was through an external kitchen door. There was a concrete wall surrounding the dumpster .</p> <p>In an interview on 01/28/2025 at 10:35AM the Maintenance Director said he was just at the dumpster. He asked if it was the side door and was told no, it was on the top. He said, Oh the wind must have blown it open. I know how y'all are with the doors being open .</p> <p>In an interview on 01/29/2025 at 4:06PM the Dietary Director asked which dumpster was open because one dumpster was only for paper, plastics, and other things, and only one dumpster was for food leftovers from the kitchen. He said the dumpster lids should have been closed. He said he was not aware that both dumpsters were his responsibility. He said the trash people may have just come or the wind blew it open. He said the risk to residents of the dumpster lid being open was they could get sick because of pest that could get inside the facility .</p> <p>Record review of the Garbage and Trash Policy dated 2023 read in part . Trash Procedure: 2. Garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722</b></p> <p>Based on observations, interviews, and record review, 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 1 facility and 2 of 4 residents (Resident #275 and Resident #278) reviewed for infection control.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure Resident #275 was placed on the appropriate contact isolation for E. Coli.</li> <li>The facility failed to ensure CNA J wore appropriate PPE for EBP when providing a shower and incontinence care to Resident #278.</li> <li>The facility failed to establish and provide documentation for a water management program as part of the infection control program.</li> <li>The facility failed to ensure dirty laundry was kept in the appropriate bin and not on the floor in the laundry room.</li> </ol> <p>These failures could place residents at risk of exposure to Legionnaires' disease (a serious type of lung infection caused by Legionella bacteria which can live in standing water within facility water systems), and other infectious diseases due to improper infection control practices.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of resident #275's undated face sheet revealed she was an [AGE] year-old female admitted on [DATE] with diagnoses of type 2 diabetes mellitus (body does not produce enough insulin or resists it), hypertension (high blood pressure), dysarthria (trouble speaking), dysphagia (trouble swallowing), urinary tract infection, ESBL resistance (type of antibiotic resistance), resistance to multiple antimicrobial (antibiotic) drugs, and left artificial hip.</li> </ol> <p>Record review of Resident #275's Admission MDS was not completed yet.</p> <p>Record review of Resident #275's care plan dated 1/27/25 revealed the resident had a urinary tract infection, and it would resolve without any complications by the review date. Interventions included giving medications and monitoring vitals/labs. The care plan also revealed the resident was on antibiotic therapy and would be free of any discomfort/adverse effects through the review date. Interventions included administering the antibiotic, and monitoring/reporting reactions.</p> <p>Record review of Resident #275's care plan dated 1/30/25 revealed the resident required contact isolation due to ESBL of the urine and she would not have any isolation at the review date. No interventions were entered yet.</p> <p>Record review of Resident #275's previous hospital records revealed lab results from 1/15/25 which indicated she had E. Coli present in drainage from her left hip.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #275's Nursing Admission Assessment from 1/26/25 at 11:55am revealed nothing was answered under the question, List of all current and resolved infections: Question 11 asked if the resident had VRE, MRSA, C-Diff or NA. It was marked NA. Question 12 asked about any other resistant infections and the answer was no. When asked if the resident had been on any precautions, the answer was also no. When asked if the resident was receiving an antibiotic, there answer was yes.</p> <p>Record review of Resident #275's chart revealed a progress note from NP H on 1/27/25 at 8:14am that said, Urinary tract infection UA with ESBL E. Coli. Currently on IV meropenem to complete the course-ID has been consulted.</p> <p>Record review of Resident #275's Physician orders revealed the following orders from MD K:</p> <ul style="list-style-type: none"> <li>- Meropenem (antibiotic) 500mg IV Q12hr for UTI. Ordered on 1/26/25 at 12:52pm.</li> <li>- Infectious Disease consult and treat, one time. Ordered on 1/27/25 at 1:40pm.</li> <li>- Contact Isolation for ESBL in the urine, every shift. Ordered on 1/29/25 at 10:58am</li> </ul> <p>In an interview and observation of Resident #275 on 1/28/25 at 8:39am, the resident had an isolation cart outside of their room but there were no isolation signs anywhere. The family said she was on IV antibiotics for E. Coli in the urine, but the resident did not have a contact isolation sign anywhere.</p> <p>In an interview and observation of LVN A on 1/28/25 at 8:43am, he said Resident #275 was on antibiotics for pneumonia. He was observed going in and out of the room with no PPE on.</p> <p>In an interview with LVN A on 1/28/25 at 9:05am, he said there were usually isolation signs on the resident's doors. He said if he did not see an isolation sign, he would have to look in the resident's chart to know what isolation precautions they were on. He said he did not know who put the isolation signs up. He said the facility did not have any medication aides and he was super busy with 4 residents on IV antibiotics, a g-tube (opening to stomach for nutrition) resident, and a trach (artificial opening in the airway) resident. He also said the families were there, so he had to take time to speak to them. LVN A said he would wear PPE, but he was in such a hurry and had so much to do, he did not have time to put PPE on. He said if PPE was not worn, the resident could get worse, or he could get something.</p> <p>In an interview with LVN A on 1/28/25 at 9:18am, he asked the Surveyor, which specific instances would he need to wear PPE for EBP, and when would he need to wear a mask? The Surveyor explained EBP to LVN A in detail.</p> <p>In an observation and interview with Resident #275 on 1/29/25 at 8:50am, the resident had Merrem on the IV pole next to her and hooked up to her PICC line (tube inserted into vein of upper arm and threaded into large vein near the heart) on her LUA. The family said no staff had come in with any gowns on the whole time she had been there, and family stay with her all during the day.</p> <p>In an interview with LVN S on 1/29/25 at 8:58am, she said Resident #275 was not on any isolation and that she only had an IV.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with LVN S on 1/29/25 at 9:15am, she said she was not sure what EBP and was confused because she had only been working at the facility for 3 days and she came from the hospital where they did not use EBP. She said she had training but it was confusing on what needed to be EBP and what did not. She said she knew g-tubes, colostomies (hole to the outside of abdomen to collect stool), trachs, and wounds needed EBP, but that was all.</p> <p>In an interview with the DON on 1/29/25 at 9:20am, she said Resident #275 was not on contact isolation and she did not know anything about the resident having E. Coli at the hospital or being on IV antibiotics for E. Coli, like the family said. She went on to say EBP was for a wound, trach, oxygen, any line, and dialysis. The Surveyor corrected her and informed her EBP was not needed for oxygen or a peripheral line, only things that were invasive. She said the correct PPE for EBP was a gown and gloves and staff should wear it during incontinence care, during any treatments, or any resident care that was up close and personal, like showering or giving IV medications. The DON said the resident was put at risk if the PPE was not worn. She said contact isolation was for MRSA, C-diff, and other resistant bacteria. She said staff should wear a gown and gloves every time they enter the room, no matter what they go in for. The DON said staff were at risk for spreading infection if PPE was not worn.</p> <p>In an interview with the DON on 1/30/25 at 10:15am, she said she contacted the MD about Resident #275 and the MD said she should be on contact isolation and IV antibiotics. The MD said she needed to stay on contact isolation until the IV antibiotics were finished. She said she normally got isolation information in report before they admitted the resident, but they did not receive any information about it. She said she was the one who reviewed the resident's chart before and after admission and she must have overlooked where it said she had E. Coli. She said the resident could spread the bacteria without being on isolation.</p> <p>2. Record review of Resident #278's undated face sheet revealed she was a [AGE] year old female admitted on [DATE] with diagnoses of epilepsy (seizures), sepsis (infection throughout body), benign neoplasm of cerebral meninges (non-cancerous tumor originating in the protective membranes of the brain and spinal cord), hemiplegia and hemiparesis (paralysis and weakness) of left non-dominant side, pneumonia, respiratory failure (not enough oxygen in the blood), tracheostomy (tube in windpipe for airway and breathing), gastrostomy (tube into stomach for nutrition).</p> <p>Record review of Resident #278's Admission MDS was not completed yet. Resident #278's BIMS score was attempted on 1/24/28 at 12:11pm, but unable to be performed due to her medical conditions.</p> <p>Record review of Resident #278's care plan dated 1/27/25 revealed the resident required tube feeding and she would remain free of side effects/complications through the review date. Interventions included keeping the HOB elevated 45 degrees during and 30min after feeding, monitor for aspiration, and monitor labs. The resident also had a tracheostomy and would have no abnormal drainage through the review date. Interventions included ensuring trach ties were secured at all times, monitoring for restlessness, agitation, confusion, suction PRN, and procedures if her trach came out.</p> <p>Record review of Resident #278's Physician Orders revealed the following orders from MD K:</p> <p>- Change trach inner cannula Shiley #6 (type of trach) PRN for mucus plug. Ordered on 1/24/25 at 11:06am.</p> <p>(continued on next page)</p>		

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  01/31/2025
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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- Enhanced Barrier precautions-wear gown and gloves with care, every shift. Ordered on 1/24/25 at 12:38pm.</li> <li>- Change catheter securement device with dressing change, PRN for central venous catheter (tube inserted into vein of upper arm and threaded into large vein near the heart). Ordered on 1/24/25 at 3:22pm.</li> <li>- Zosyn (antibiotic) 3.375 gm/50ml IV Q8hr for UTI. Ordered on 1/24/25 at 3:29pm.</li> <li>- Jevity (g-tube nutrition)1.5 300ml QID, Flush 200ml H2O QID. Ordered on 1/24/25 at 3:54pm.</li> <li>- Refer resident to Infectious Disease doctor consult. Ordered on 1/26/25 at 5:58pm.</li> </ul> <p>In an interview and observation of Resident #278 on 1/28/25 at 9:21am, the resident was lying in bed with a trach, g-tube, and RUA midline. A family member and CNA J were providing incontinence care and getting her dressed. CNA J was not wearing a gown and was only wearing gloves. The family member said he helped out whenever possible and the staff were great at providing assistance.</p> <p>In an interview with CNA J on 1/28/25 at 9:46am, he said EBP was when staff wore a gown and gloves, and it was for residents with a catheter or g-tube but did not know any other times. He said the reason for wearing the PPE was it was better safe than sorry. He said he had not had a resident like resident #278 in at least 6mths so he did not remember what he was supposed to do for isolation and PPE. Once EBP was explained to him he said, That's a lot of residents to wear PPE for. We're going to run out!</p> <p>In an interview with LVN S on 1/29/25 at 8:58am, she said Resident #278 was on contact isolation for MRSA of the nares.</p> <p>In an observation on 1/29/25 at 8:59am, Resident #278 had a big red sign on her door that said, Check with nurse before entering.</p> <p>In an interview with the Administrator who was also the Infection Preventionist, on 1/29/25 at 9:29am, she said EBP was for any wound, tube, line, including oxygen. The Surveyor explained the Administrator that oxygen did not need to be on EBP. She said staff were expected to wear gowns and gloves when they were physically touching the resident or giving an IV antibiotic, but not if they just walked into the room. She said the PPE was to protect staff and residents. She said the isolation signs were placed right inside the door, on the wall.</p> <p>3. In an interview with the Maintenance Director on 1/29/25 at 2:45pm, he said he had been at the facility for about 1.5yrs and did not know anything about a water-borne illness policy or program. He said he did not check for any standing water and only checked the temperatures of the water and had measurements in place to prevent backflow.</p> <p>In an interview with the Administrator on 1/29/25 at 3:00pm, she said she did not know anything about having a water-borne illness policy or plan. She said she did perform a Legionnaire's test once a year. She said no one had ever had Legionnaire's disease. She said the risk was possibly Legionnaire's disease.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. In an observation of the laundry room on 1/29/25 at 2:45pm, there were no laundry staff anywhere. There was a pile of dirty laundry on the floor instead of in a dirty laundry bin.</p> <p>In an interview with the Maintenance Director on 1/29/25 at 2:45pm, he said there was not supposed to be dirty laundry on the floor because it could cause cross contamination. He said he was responsible for overseeing the laundry room.</p> <p>Record review of the facility's policy and procedure on Scope of Infection Control Program (Revised June 2022) read in part: The policy will provide the scope of the infection control program for the facility. The facility 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 .Standard and transmission-based precautions to be followed to prevent spread of infections. When and how isolation should be used for a resident; including but not limited to: The type and duration of the isolation, depending upon the infectious agent or organism involved .Personnel handling, storing, processing and transport of linens to prevent spread of infection .Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Contaminated laundry refers to laundry which has been soiled with blood/body fluids or other potentially infectious materials or may contain sharps. Legionellosis refers to two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is typically characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and Pontiac fever, a milder illness without pneumonia (e.g., fever and muscle aches). Legionellosis is caused by Legionella bacteria .Staff will follow standard and transmission-based precautions to prevent spread of infections. Staff will use isolation precautions for a resident; including but not limited to: the type and duration of the isolation, depending upon the infectious agent or organism involved .</p> <p>Record review of the facility's policy and procedure on Water Management Program (Revised June 2022) read in part: It is the policy of this facility to prevent and control spread of Legionnaire's Disease through a water management plan system .The Administrator in Coordination with Director of Nurses and/or its designee shall be responsible for implementation and enforcement of this policy. Report all suspected and confirmed outbreaks .Facilities must be able to demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program. Water management must be based on nationally accepted standards .An assessment to identify where Legionella and other opportunistic waterborne pathogens .could grow and spread; and Measures to prevent the growth of opportunistic waterborne pathogens .and how to monitor them.</p> <p>Record review of the facility's policy and procedure on Laundry Services (Revised November 2017) read in part: .To ensure that the Facility provides laundry services that meets the needs of the resident. The Maintenance Supervisor or Housekeeping Supervisor and/or its designee shall be responsible for implementation and enforcement of this policy. Onsite Laundry Services: When the Facility operates its own laundry, the laundry: Is maintained in a clean and sanitary condition. Has written procedures for handling, storage, transportation and processing of linens posted in the laundry room .</p>		