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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 16.0% based on 4 errors out of 25 opportunities, which involved 2 of 4 residents (Resident #22 and Resident #82) reviewed for medication administration. 1. MA J failed to properly verify and dispense Furosemide (diuretic) according to physician's order with a start date of 01/10/2026 for Resident #22 when on 04/08/2026 MA J dispensed and was going to administer Resident #22 with two 80MG tablets instead of one 80MG tablets until surveyor intervention. 2. MA J failed to administer Calcium-Vitamin D 600-200 MG (supplement) according to physician's order with a start date of 03/17/2026 to Resident #22, when on 04/08/2026 MA J did not administer Calcium-Vitamin D supplement to Resident #22, resulting in a missed dose. 3. LVN A failed to properly verify and dispense Amantadine (antiparkinsonian) according to physician's order with a start date of 4/4/2026 for Resident #82 when on 4/8/2026 LVN A dispensed and administered approximately 16ml instead of 20ml resulting in insufficient amount. 4. LVN A failed to properly verify and dispense Doxazosin Mesylate (anti-hypertensive) according to physician's order with a start date of 4/4/2026 for Resident #82, when on 4/8/2026 LVN A administered additional 4mg on top of 8mg resulting in overdose. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health.Findings included: Record review of Resident #22's face sheet dated 04/08/2026 revealed an [AGE] year-old female with an initial admission date of 01/10/2026. Resident #22 had diagnoses which included: end stage renal disease (permanent kidney failure), shortness of breath, chronic kidney disease and atherosclerotic heart disease (damage of the major blood vessels). Record review of Resident #22's MDS (Minimum Data Set) Medicare 5 days assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 8, which indicates the resident has moderate cognitive impairment with thinking and memory. Record review of Resident #22's medication administration record for April 2026 revealed an order with a start date of 01/10/2026 for Furosemide Oral Tablet 80 MG Give 1 tablet by mouth three times a day. and an order with a start date of 3/17/2026 for Calcium-Vitamin D Tablet 600-200 MG Give 1 tablet by mouth one time a day. During medication observation for Resident # 22 on 4/8/2026 at 9:41 Am, MA J dispensed 7 tablets into the medication cup for Resident #22. Prior to MA J entering resident's room, surveyor intervened and stopped MA J and counted the number of pills in the medication cup. Surveyor told MA J that there was an extra pill in the cup. MA J looked at the cup and said all the pills are correct. Surveyor told MA J to count again, and this time MA J identified that she had mistakenly dispensed 2 pills for Furosemide instead on 1 pill. Surveyor instructed MA J to read the instructions on the medication card for Furosemide which stated 80 MG give 1 tablet. MA J said she thought it was a 40 MG tablet and Resident # 22 should receive 2 pills to equal 80 MG. MA J removed the extra Furosemide pill and notified her nurse. MA J administered the correct number of medications to Resident #22. At 9:51 Am charge nurse LVN B discarded the extra pill. During an interview with MA J on 4/8/2026 at 9:50am, MA J stated she should verify the orders against the medication card to prevent errors. MA J stated Resident #22 could have an adverse effect and complication if medications were administered (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inaccurately. During record review and medication reconciliation it was identified MA J did not administer Calcium-Vitamin D 600-200 to Resident #22 during medication observation on 4/8/2026 at 9:41am. During an interview with the DON on 4/8/2026 at 3:05PM, DON reviewed electronic medication administration record (eMAR) for Resident #22 and stated Calcium-Vitamin D was not administered. DON stated MA J documented in eMAR that this medication was not available. DON stated this medication is over the counter medication and should be available and should not be skipped. DON stated her expectation is for nurses and medication aides to replenish their medication carts with over the counter medications accordingly. Record review of Resident #82's face sheet dated 04/07/2026 revealed a [AGE] year-old male was admitted to the facility on [DATE]. His diagnoses include dysphagia following cerebral infarction (difficulty swallowing after a stroke), hypertension (condition where the force of blood pressure against the artery wall is consistently too high), cerebral infarction (a type of stroke caused by blockage of blood vessel leading to cell death due to lack of oxygen) and aneurysm of the ascending aorta without rupture (a weakened, balloon like bulging in the main artery leaving the heart). Record review of Resident #82's MDS Medicare 5 days Nursing Home PPS (NP) assessment dated [DATE] revealed under section C0500 a BIMS score of 99 which indicated resident was unable to complete the interview. Record review of Resident #82's of current physician order revealed an order with start date of 4/4/2026 for Amantadine HCL oral Solution 50MG/5 ML Give 20 ml via Peg tube one time a day. and an order with start date on 4/4/2026 for Doxazosin Mesylate Oral tablet 2MG Give 4 tablets via peg tube one time a day for essential hypertension . administer 4 tabs to = 8MG daily. During an observation of medication administration for Resident #82 on 4/8/2026 at 8:39AM, LVN A dispensed 16ml of Amantadine HCL in medicine cup and administered the medication via g-tube. LVN A dispensed 1 tablet of Doxazosin 8MG and 1 tablet of Doxazosin 4mg in individual pill cups and crushed each medication individually and administered via g-tube. After completing medication reconciliation, it was identified LVN A failed to read the orders correctly and administer the correct amount of Amantadine HCL and Doxazosin Mesylate. During an interview with LVN A on 4/8/2026 at 2:24 PM, she verified the eMAR for Resident #82 and stated there was no order for Doxazosin 4mg. LVN A stated resident should only be receiving 8mg of Doxazosin. LVN A stated she had administered more than Resident #82 required. LVN A stated this could place Resident #82 at risk for negative outcome. LVN A stated she will notify MD. During an interview with the DON on 4/8/2026 at 3:05PM, DON stated LVN A should read the orders correctly and verify the medication card prior to administering the medication. DON stated her expectation is for nurses to administer medications accurately to prevent negative outcomes and complications. DON stated she will do 100 percent cart audit to remove unnecessary medication, will review all medication orders during daily morning meetings and will notify MD. On 4/9/2026 at 9:15am DON stated Resident #82 was put on vital signs monitoring every 4 hours and assessed for any changes. Record review of the facility's job description for Nursing Licensed Vocational Nurse, dated May 2017, read in part . Position Summary: Under the direct supervision of a registered nurse, implements the established plan of care for each assigned group of residents. Responsibilities include. administration of medications .5. POSITION RESPONSIBILITIES/DUTIES: h. Administers medications in a proficient manner, including pain management .

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen observed for sanitization. The facility failed to ensure foods were properly stored, labeled, and dated. These failures placed all residents who consumed food served by the kitchen at risk of food-born illness. Observation of the kitchen on 4/7/2026 at 8:15 a.m. revealed the following: Insulated dome covers and bases and plates were stored on a 5-tiered shelf adjacent to the steam table and next to a floor drain. These stored items had crumb like beige particles noted over the insulated bases on the lowest shelf. There were two unopened packets of ketchup on the bottom shelf in between the insulated bases. There was a cup of white solution on the 3rd shelf covered undated or labeled. The floor area around the shelf was littered with particles on the floor. The shelf was not clean as evidenced by discoloration and particles adhered to the surface of the shelves. In the dry pantry, 3 packaged stacks of corn tortillas with an expiration date of 12/24/2024. One of the stacks was knotted closed without a dated label. In the dry pantry, a partially wrapped package of pasta that was opened to air without a label or date. In the dry pantry, a large clear bin filled with a white substance on the lowest shelf with a label with a handwritten dates that read 1/2/2026. Shelf life 1/6/2026 along with a barcode label that had a delivery date of 6/2/2025. Observation of the walk-in refrigerator on 4/7/2026 at 8:30 a.m. revealed the following: One container of peeled cooked eggs with an expiration date of 3/26/2026. One large gallon size Ziplock back that had solid red contents that was not labeled and dated.3 large plastic clear bins filled with a yellow solution inside that were not labeled and dated.2 white buckets of Rich's chocolate stacked on top of each other with an expiration date of 12/28/2025. Both buckets had furry black spots 1-2 cm in diameter circular areas over the sides and lids. Observation of walk-in freezer on 4/7/2026 at 8:44 a.m. revealed the following: A package of unknown white cubed contents wrapped in clear wrapping that was not labeled or dated and opened to air. One gallon size Ziploc bag of unknown red contents that was not labeled or dated.One bag of Mozzarella breadsticks that was opened to air without a label or date. During an interview on 4/7/2026 at 9:26 a.m., the Head [NAME] stated the kitchen staff did not have a dietary manager. The head [NAME] stated she had worked at the facility for 3 years. The Head [NAME] stated that the former dietary manager's last day was 4/6/2026. The Head [NAME] stated that it is a team effort to keep the kitchen clean, and to discard expired foods. The Head [NAME] stated that whoever opened a food item is responsible for labeling and dating it. The Head [NAME] stated she was not aware of expired, unlabeled and undated food in the pantry, refrigerator, or freezer. The Head [NAME] stated that the three bins of yellow liquid in the refrigerator were lemonade made 4/6/2026 to be served on 4/7/2026. The Head [NAME] stated the lemonade should have been labeled and dated. The Head [NAME] stated the former manager took items out of their boxes and did not label or date food items in the freezer. During an interview on 4/7/2026 at 11:45 am, Dishwasher A stated he worked intermittently at the facility since November 2025. Dishwasher A stated he was not responsible for storing, labelling or dating food items. During an interview on 4/9/2026 at 10:16 a.m., [NAME] A stated she had worked at the facility for one year. [NAME] A stated that all food items that were opened should be dated and labeled. [NAME] A stated that she was not aware of expired food in the kitchen or food being stored without a proper label with date. [NAME] A stated the Head [NAME] trained her for her position as a cook. [NAME] A stated whoever opens food should label and date it. [NAME] A stated if residents ate expired foods it could lead to sickness. During an interview on 4/9/2026 at 10:21 a.m., [NAME] B stated he had worked at the facility for 5-6 months. [NAME] B stated that he was not aware of expired food in the kitchen or food being stored without a proper label with date. [NAME] B stated the training he received from the facility was given by his former manager. [NAME] B stated whoever opens food should label and date (continued on next page)

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it. [NAME] B stated the risk to residents of eating expired food could lead to infection, sickness, or death. During an interview on 4/9/2026 at 10:30 a.m., the Tray Aide stated he had worked at the facility since July 2025. The Tray Aide stated that his main duties include assembling the trays. The Tray Aide stated that he washed dishes at night sometimes and was trained for position by another kitchen employee who no longer works at the facility. The Tray Aide stated the risks to residents of eating expired food could lead to infection, sickness, or death. During an interview on 4/9/2026 at 10:54 a.m., the Interim Administrator stated the newly hired dietary manager would begin his role officially on 4/15/2026. The Administrator stated that the previous dietary manager left the faciity on 4/6/2026. During an interview on 4/9/2026 at 12:27 p.m., the Head [NAME] stated that she had helped train [NAME] A. The Head [NAME] stated the former manager trained all other kitchen staff. The Head [NAME] stated the risk to residents of eating expired food was sickness, infection, or death. During an interview on 4/9/2026 at 12:50 p.m. the Interim Administrator stated that dietary manager was responsible for training kitchen staff in their duties. The Interim Administrator stated that he does not know where training records are located for kitchen staff. The Interim Administrator stated the dietician was a resource for kitchen staff. The Interim Administrator stated the risks to residents of eating expired food were infections. During an interview on 4/9/2026 at 3:20 pm, the Dietician stated he worked for the facility for 2 years. The Dietician stated she was considered PRN and visited the facility 2-3 times a week. The Dietician stated her duties included being present for IDT meetings, completing nutritional assessments, kitchen audits, and orientating dietary members. The Dietician stated that the Dietary manager was responsible for training kitchen staff. The Dietician stated the former dietary manager had a scheduled of audits he would perform which included checking for proper labeling and dating of food items. Record review revealed the Head [NAME] had a certificate labeled Food Handler Essentials Course issued on August 9, 2025, issued by StateFoodSafety. Record review revealed [NAME] A had a certificate labeled Food Handler Essentials Course issued August 2, 2025, valid for 2 years issued by StateFoodSafety. Record reviewed revealed Tray Aide had a certificate labeled Food Handler Essential Course issued August 9, 2025, valid for 2 years issued by StateFoodSafety. Record reviewed revealed certificates issued by StateFoodSafety included training on how to responsibly prepare and store food, prevent foodborne illness, and maintain a sanitary food preparation environment. Record review revealed [NAME] B had a certificate labeled Food Handler Training Program issued on 10/25/2023 by SafeStaff with an expiration date of 10/25/2026. Record review of facility policy titled Food Storage Principles dated April 2020 read in part, 3. Proper food storage is essential for preserving food quality. This applies to foods stored prior to preparation, and also to prepared foods (leftovers) placed in storage.3. Label each package, box, can, etc. with the expiration date, date of receipt, or when the item was stored after preparation.discard foods that have exceeded their expiration date.discard leftover foods that have not been used within 48 hours of preparation.keep food storage areas clean and free of spills and leaks.

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided a PASRR level II evaluation for 2 of 4 (Resident # 17 and Resident #4) residents reviewed for resident assessments.The facility failed to correctly identify Resident #17 and Resident #4 as having a mental illness in their PASRR Level 1 Screening and completing a PASRR Level II.This failure could place residents with documented mental illness diagnoses at risk of not receiving needed care and therapy services in the appropriate setting.Findings included:Resident # 17Record review of facility face sheet revealed Resident # 17 was a [AGE] year-old female with an initial admission date of 9/17/2025. Resident # 17's primary diagnosis upon admission were Epilepsy (a brain condition that causes recurring seizures), as well as Schizophrenia (a serious mental health condition that affects how people think, feel, and behave), Hemiplegia (severe or complete paralysis) and Hemiparesis (mild to moderate weakness) following Nontraumatic Intracerebral Hemorrhage (a severe type of stroke caused by bleeding with brain tissue) affecting left non-dominate side and Cognitive Communication Deficit.Record review of Resident #17's Quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment and detailed active diagnoses of Seizure Disorder or Epilepsy and Schizophrenia.Record review of Resident #17's Care Plan dated 1/27/2026 revealed focus area related to medication for seizure control and Schizophrenia manifested by hallucinations as well as focus area related to left-sided Hemiplegia.Record review of Resident #17's orders revealed medication Olanzapine (treatment for Antipsychotic with behaviors of hallucinations) order date 9/17/2025 and Keppra Oral Solution (treatment for seizures) order dated 1/15/2026.Record review of Resident #n17's PASRR dated 9/17/2025 indicated in Section C NO to Is there evidence or an indicator that this is an individual that has a Mental illness and NO to Is there evidence or an indicator that this is an individual that has a Developmental Disability. No additional or updated PASRR was located or completed for this resident. Resident# 4Record review of facility face sheet revealed Resident #4 was an [AGE] year-old-female with an initial admission date of 4/17/2023 and current admission date of 3/5/2026. Resident #4's primary diagnosis upon admission were Acute Pyelonephritis (a sudden bacterial infection of one or both kidneys), as well as Psychotic Disorder with Delusions (a type of mental health condition in which a person cannot tell what is real from what is imagined) due to known Physiological Disorder (an abnormal physical function or alteration in the body's organs) and Bipolar (a chronic mental health condition characterized by severe mood swings ranging from extreme highs to intense lows).Record review of Resident #4's MDS dated [DATE] revealed a BIMS score of 4 indicating severe cognitive impairment and detailed active diagnoses of Bipolar and Psychotic Disorder.Record review of Resident #4's care plan dated 3/6/2026 revealed focus area related to medication for bipolar disorder.Record review of Resident #4's medication orders for Risperdal (treatment for bipolar disorder) order date 12/31/2025.Record review of Resident # 4 PASRR dated 4/17/2023 and additional PASRR dated 7/28/2023 indicated in Section C NO to Is there evidence or an indicator that this is an individual that has a Mental illness and NO to Is there evidence or an indicator that this is an individual that has a Developmental Disability. No additional or updated PASRR was located or completed for this resident.Interview on 4/9/2026 at 9:30 am and 4:43pm with Social Services stated Nursing Department looks over any discharge information or hospital records for a new admit regarding diagnoses and care needs. Social services looked over any hospital records for new admits to complete parts of the MDS and review PASRR from previous facility or complete if not coming from a previous facility. Social Services stated if a resident has a change in condition or a history of aggression, sexual abuse, mental disorders then a PASRR Level II screening would be completed. Social Services reviewed records of Resident # 17 current and admitted diagnosis of Epilepsy and Schizophrenia and Resident # 4's current and admitted diagnosis of bipolar disorder. (continued on next page)

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Services stated these diagnoses would require Level II PASRR and an updated Level I PASSR to reflect the mental illness. Social Services stated both residents were receiving services for Psychological Services with a contracted provider. Social Services stated he was not present at the facility when Resident #4 was admitted in April 2023 or Resident #17 in September 2025 to have reviewed their PASRR. Social Services stated residents that are short-term stay typically would not have a new PASRR unless the residents were transferred to another facility or a change in conditions happens. Social Services stated residents were not at risk of not receiving services due to having therapy services with a contracted provider.Interview on 4/9/2026 at 2:08pm with the DON she stated her expectations for completing the PASRR Level I and Level II were to follow the policy from the RAI manual. DON stated she has been at the facility for 4 days and was not aware of the incorrect PASSR for Resident #17 or Resident #4.Interview on 4/9/2026 at 2:32 pm with MDS Nurse she stated she began working with the facility December 2025. MDS Nurse reviewed records of Resident #4 had a Bipolar diagnosis in [DATE]. MDS Nurse stated Section C of the PASRR should have been changed in July of 2023 to reflect most recent PASRR date for Resident #4. MDS Nurse reviewed records of Resident # 17's diagnosis of Schizophora. MDS Nurse stated a Level II PASRR would not be eligible for Resident #17 due to being private pay, however Resident #17 would still need outside services for her diagnosis. MDS Nurse stated they (MDS, Nursing, Social Services) are to review Level I PASRR along with admitting diagnosis to verify information. MDS Nurse stated if a resident was at the facility for over 2 weeks, they are to redo PASRR and contact PASRR with any changes if needed. MDS Nurse stated she was not aware of Resident #17 or Resident #4 diagnoses due to not having access to notes/ records for either resident. MDS Nurse stated the purpose of PASRR Level II was to be sure residents get needed services like therapy and a PASRR that was not accurate could risk a resident not getting the services they needed.Interview on 4/9/2026 at 4:31 pm with Administrator he stated he began at the facility March 2026. He stated when there was an admission of a resident the documentation was reviewed by Social or Case management to see if there was a need for a PASRR Level II. Administrator stated his duties would be to review the PASRR was completed and accurately by the Social Worker or Care manager. Administrator said potential risks were services not being provided. He stated he was unsure of staff training for PASRR since he began at the facility.Record review of facility policy Pre-admission Screening and Resident Review (PASRR) dated December 2022 read in part The facility shall ensure that all prospective residents undergo the PASRR Level I screening before admission. If a Level I screening indicates the presence of SMI, ID, or DD, a PASRR Level II evaluation will be conducted before admission. The facility will comply with all state and federal regulations to ensure appropriate placement and services for PASRR-identified individuals.

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #82) of 3 residents reviewed for enteral nutrition. -The facility failed to ensure LVN A followed the appropriate procedure for verifying tube placement, administering flushes and medication during enteral tube medication administration. -The facility failed to ensure LVN A inserted small amount of air into the tube to listen for stomach gurgling sound or aspirate stomach content to check for placement. -The facility failed to ensure LVN A used the appropriates amount of water to dilute medication and to flush in between medication administration. These failures could place residents with gastrostomy tube at risk for complications, aspiration, and pneumonia. Findings included: Record review of Resident #82's face sheet dated 04/07/2026 revealed a [AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included dysphagia following cerebral infarction (difficulty swallowing after a stroke), hypertension (condition where the force of blood pressure against the artery wall is consistently too high), cerebral infarction (a type of stroke caused by blockage of blood vessel leading to cell death due to lack of oxygen) and aneurysm of the ascending aorta without rupture (a weakened, balloon like bulging in the main artery leaving the heart) Record review of Resident #82's MDS Medicare 5 days (Nursing Home PPS (NP) assessment dated [DATE] revealed under section C0500 a BIMS score of 99 which indicated resident was unable to complete the interview. Record review of Resident #82's clinical physician's order read in part .check tube placement before initiation of formula, medication administration and flushing tube. document residual. Hold feeding for residual >150. Record review of Resident #82's medication administration record for April 2026 read in part .flush feeding tube. 30cc of water before and after medication administration. During an observation of medication administration for Resident #82 on 04/08/26 at 8:39 a.m., LVN A took the following medications from the med cart to prepare for medication administration: Amantadine HCL 50mg/5ml give 20ml via g-tube every morning and evening, Amlodipine 10mg give 1 tab via g-tube daily, Amoxicillin-Pot Clavulanate Tablet 875-125mg take 1 cap via g-tube every 12 hours, Vitamin C 500mg take 1 tab twice daily, Donepezil HCL 10mg take 1 tab daily, Doxazosin Mesylate 8mg tab take 1 tab daily, Doxazosin 4mg take 1 tab daily, Metoclopramide 10mg take 1 tab every 6 hours. LVN A poured approximately 16ml of Amantadine HCL into the medicine cup and crushed the remaining tablets separately and poured into individual medicine cup. LVN A poured 5ml of water into each medication cup containing the crushed medication. LVN A put the plunger into the end of the g-tube and poured 30ml of water and let it flow via gravity. LVN A stated she uses 30ml of water before and after medication administration and 10 ml of water in between each medication. LVN A started administering each crushed medication one by one followed by 10ml of water in between each medication via flow of gravity. LVN A completed the medication administration with 30ml of water after administering the last crushed medication. LVN A turned around and looked at the individual medicine cups and stated there were residuals of the crushed medication remaining in some of the cups. 5 of the 8 medicine cups had residuals of the crushed medications. LVN A stated she should have brought a spoon to stir the crushed medications so that it was dissolved completely. LVN A stated she could not identify which were the medications that had the crushed medicine residual in the medicine cups. LVN A gathered more water and spoon. LVN A poured 5 ml of water into each of the 5 remaining cups and stirred the residual crushed medications to completely dissolve. LVN A proceeded to administer the remaining 5 residual crushed medications starting with 30ml water with 10 ml of water in between each medication and ending with 30 ml water. During an interview with LVN A on 4/8/26 at 9:15am, LVN A stated she did not check for placement prior to initiating medication administration. LVN A stated she did not aspirate stomach (continued on next page)

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	content. She stated she just looks at the water going down the g-tube and knows that the medications are going into the stomach. LVN A stated she was using the right amount of water to dilute the mediation and to flush in between medications. LVN A stated if the g-tube placement is not verified, Resident #82 could have complications from medications going into other areas. LVN A stated Resident #82 would not get the full benefit of his medications if there were residuals of crushed medications remaining in medicine cup. LVN A stated if the mediations are not dissolved completely, it could get stuck in the g-tube. LVN A checked the physician's orders for Resident #82 and stated she did not administer 20ml of Amantadine HCL as per physician's orders. LVN A stated Resident #82 will not get the full benefit of the prescribed medication if the correct amount is not administered. During an interview with the DON on 4/8/26 at 9:20am, DON stated she will need to verify the Enteral Feeding Policy to determine g-tube placement verification and water flushes for medication administration. DON stated it was important to check for placement prior to medication administration to prevent complications. DON stated she will work with pharmacy to change Resident #82's medication into liquid form to ensure Resident #82 receives the full amount of his medications. Record review of the facility policy titled POLICIES AND PROCEDURES - Pharmacy Services for Nursing Facilities 2006 - Specific Medication Administration Procedures IIB13: Enteral Tube Medication Administration read in part. The purpose: To safely and accurately administer oral medications through an enteral tube.Procedures:.#N. Verify tube placement, #13) Unclamp tube and use either of the following procedures: #a. Insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope or gurgling sound; or #b. Aspirate stomach contents with syringe.#16) Crush tablet and dissolve in 30ml of warm water or other appropriate liquid.#T. Administer each medication separately, flushing tube with 5ml of water after each dose.

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the expiration date when applicable for 2 (400 hall cart and 600 hall cart) out of 3 medication carts reviewed for labeling and storage of drugs.The facility failed to ensure Resident # 31's Ipratropim Bromide 0.02 mg/Albuterol sulfate (a medication that helps open the airways and reduces breathing difficulties) 2.5ml/3 ml inhalation solution was labeled with the expiration date and discarded after 14 days according to facility policy.The facility failed to ensure Resident #6's Ipratropium 0.02%/2.5ml (a medication that helps open the airways and reduces breathing difficulties) inhalation solution was labeled with the expiration date and discarded after 14 days and according to facility policy.The facility failed to ensure Resident #6's Levalbuterol 1.25 mg/3ml (a medication that helps open the airways and reduces breathing difficulties) inhalation solution was labeled with the expiration date and discarded after 14 days and according to facility policyThe facility failed to ensure Resident #6's Ipratropium Bromide 0.5 mg/Albuterol sulfate 2.5 mg/3ml (a medication that helps open the airways and reduces breathing difficulties) inhalation solution was unlabeled with the open date.These failures could place residents at risk of not receiving the intended therapeutic effects of prescribed medications or receiving potentially harmful side effects from expired prescribed medications. Record review of Resident #31's admission face sheet dated 4/9/2026 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included unspecified dementia (refers to cases where the specific type of dementia cannot be clearly identified, despite the presence of cognitive decline and memory loss), unspecified respiratory disorder (broadly refers to any condition affecting the airways or lung tissue that prevents the respiratory system from functioning properly, resulting in symptoms like breathlessness, chronic coughing, or low oxygen levels), and essential hypertension (a type of high blood pressure that has no identifiable cause).Record review of Resident #6's admission face sheet dated 4/9/2026 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Chronic respiratory failure (a long-term condition where the lungs cannot adequately transfer oxygen into the blood or remove carbon dioxide) and pleural effusion (abnormal buildup of excess fluid between the thin membranes lining the lungs and the chest cavity).During an observation on 4/8/2026 at 9:51 a.m. of the 400-hall medication cart with LVN D, Resident #31 had1. One opened box of Ipratropim Bromide 0.02 mg/Albuterol sulfate 2.5ml/3 ml with an opened foil packet inside with 3 vials inside with a written date of 1/16/2026.During an interview on 4/8/2026 at 9:55 a.m., LVN D stated she was not sure what the facility policy was on expiration of opened foil packet inhalation solutions. LVN D stated the risk to residents who received expired medication was residents not receiving the full relief of their symptoms.During an observation on 4/8/2026 at 10:15 a.m. of the 600-hall medication cart with LVN N, Resident #6 hadOne opened box of Ipratropium 0.02%/2.5ml inhalation solution with an opened foil packet with 2 vials and a written date of 3/18/2026.One opened box of Levalbuterol 1.25 mg/3ml inhalation solution with an opened foil packet with 2 vials and a written date of 3/14/2026.One opened box of Ipratropium Bromide 0.5 mg/Albuterol sulfate 2.5 mg/3ml inhalation solution with an undated opened foil packet with 4 vials inside. During an interview on 4/8/2026 at 10:20 a.m., LVN N stated opened foil packets of inhalation packets have an expiration date of 30 days but was not completely sure. LVN N stated she was not aware that Resident #6 had an undated medication in her cart. LVN N stated that the risk of administering expired medications to a resident included not getting the full intended benefit of the medication or adverse reactions. LVN N stated she had worked at the facility since 2025.During an interview on 4/9/2026 at 8:46 a.m., the DON stated that 4/9/2026 was her third day at the facility in the capacity as the DON. The DON stated she spoke (continued on next page)

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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the facility's pharmacy who stated that opened foil packets of inhalation solution expired 14 days after opened. The DON stated that all opened foil packets of inhalation solutions expired 14 days and should be labeled with the opened date and expiration date. The DON stated that the risks involved with administering expired medications to residents included medication not being effective and continued symptoms.During an interview on 4/9/2026 at 9:45 a.m., the ADON stated that she had worked at the facility since September 2025. The ADON stated that opened foil packets of inhalation solutions have an expiration date of 14 days. The ADON stated the risk to residents of receiving expired medications was ineffectiveness of medication. The ADON stated that all nurses are expected to discard expired medication and to label medication with the opened and expiration date.During an interview on 4/9/2026 at 9:54 a.m., the DOD stated she helped conduct in-services for nurses and medication aides. The DOD stated that less than 2 weeks ago, she conducted an in-service on medication carts and when to remove medication from the cart. The DOD stated that opened foil packets of inhalation solutions expired in 14 days, but every medication has a different discard date. The ADON stated the risk to residents of receiving expired medication included less relief and ineffectiveness. The DOD stated the former DON checked medication carts every morning. The DOD stated that she does not use the recommendations from spot checks performed by the consultant pharmacy.Record review of facility policy titled Medication Storage Review not dated, read in part. Inhaled items must have date open on the inhaler itself or HHN foil packet.foil packets of HHN expire 14 days after foil open.Record review of facility policy titled Medication Storage in the Facility dated 2006, read in part. M. Outdated, contaminated, or deteriorated medication and those in containers that cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal.