

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Lampstand Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 E 29th St Bryan, TX 77802	
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 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526 Based on observation, interview, and record review, the facility failed to provide and document an effective discharge planning process that focused on the resident's discharge goals, the preparation of the residents to be active partners and effectively transition them to post discharge care, and the reduction of factors leading to preventable readmissions for 1 of 6 (Resident #1) of residents reviewed for safe discharge. On 4/26/2024 the facility discharged Resident #1 from the facility pending a hearing for an appeal. The facility transported Resident #1 and all of his belongings to RP1's home. There was no one at the home who was able to accept Resident #1, the facility left the resident sitting outside of the home that was located on a busy street. Resident #1 was considered blind, was moderately cognitively impaired, was at risk for elopement with a previous history of elopement. The facility failed to ensure a safe discharge for Resident #1 when the facility dropped Resident #1 off at his RP1's home on the front porch unsupervised. The facility failed to ensure and coordinate the discharge of Resident #1 with RP1. The facility failed to ensure the completion of the discharge appeal process prior to discharging Resident #1 An (IJ) Immediate Jeopardy was identified on 4/27/2024 at 3:40 p.m. The IJ Immediate Jeopardy template was provided to the Admin on 4/27/2024 at 3:40 p.m. While the (IJ) Immediate Jeopardy was removed on 4/30/2024 at 4:05 p.m., the facility remained out of compliance at a scope of isolated and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This failure could place residents at risk of an unsafe discharge from facility leading to hospitalization , injury, elopement, and death. Findings included: (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 676019	If continuation sheet Page 1 of 6

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's face sheet dated 4/27/2024 reflected, Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Unspecified Dementia (when symptoms and findings of cognitive dysfunction do not meet the criteria for a specific type of dementia), Unspecified Severity, without behavioral disturbance, psychotic disturbance (paranoid or delusional), mood disturbance (depression), and anxiety (worry), and blind. The face sheet listed RP 1 and RP 2 as the RP's for Resident #1. Record review of Resident #1's quarterly MDS dated [DATE] reflected in Section A identification information indicated Resident #1 preferred language was Spanish. Under section C cognitive patterns reflected a BIMS score of 8 indicating moderate impairment for daily decision making. Under section G functional status and ADL's reflected Resident #1 required supervision with transfers, eating, toileting. Record review of Resident #1's care plan dated 4/25/2024 reflected Resident #1 had impaired vision, at risk for falls due to vision, confusion and poor comprehension. The care plan reflected Resident #1 was an elopement risk and a previous elopement from the facility on 10/22/2023. Interventions indicated watch for wandering behaviors, request to leave, attempt to leave facility, home, or hospital. The care reflected an ADL performance deficit and required 1x staff assistance with bathing, mobility, toileting, and dressing. The care plan also reflected that a discharge from the facility is not feasible as evidenced by Resident #1's dementia, inability to care for himself, administer medications, and recognize a change in condition. In an interview via phone on 4/26/2024 at 12:30 p.m. with Resident #1 RP2, she stated the facility dropped Resident #1 off on Resident #1's RP1's front porch. She stated there was no one home and she was leaving as soon as possible to go to the home because Resident #1 was unattended. She stated she could see him on the camera all alone with his belongings. In a follow-up interview she stated she arrived to find Resident #1 confused on the doorstep of RP1's home. She reported it took her about 15 minutes to get to home, so Resident #1 was there for that period of time with no supervision. She stated Resident #1 did not know where he was and thought he was in a different state. She did not understand how the facility could leave him unattended when there is a busy street nearby. She stated he could have fallen or been hit by a car. She stated they did receive a discharge notice from the facility but filed an appeal with the assistance of an ombudsman. She stated she thought the facility could not discharge Resident #1 until the appeal was decided. She stated they cannot care for Resident #1 at home as his medical needs are high and that is why he required nursing facility care. (continued on next page)		

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 4/27/2024 at 12:45 p.m. the Admin stated on 4/26/2024 she and other staff members dropped Resident # 1 off at RP1's home. The Admin stated on 4/23/2024 the facility issued the family an emergency discharge of Resident #1 due to ongoing behaviors at the facility. The Admin stated the family did file and appeal for this discharge she stated the facility moved forward with the discharge and did not wait on the appeal process because they had already spoken with the family and started the discharge process due to the residents behavior. The Admin stated they provided the family with three choices for Resident #1, she stated they tried to locate another placement for the resident, and none were found. She stated the facility tried to get Resident #1 sent to the behavioral psychiatric hospital, she stated he was not accepted because he was not having current behaviors. The Admin stated the last choice was Resident #1 was going to be discharged to the family. She stated the family was going to have a family meeting on 4/25/2024 and let the facility know what they decided. The Admin stated she never heard back from the family so the facility discharged Resident #1 to RP1's home on 4/26/2024. The Admin stated she was not aware of who the person was who answered the door, but stated it was not either of the RPs for Resident #1. The Admin stated when they dropped Resident #1 off at the home they did not speak with or see either of the RPs for Resident #1 but thought they may have been in the home. The Admin stated she left the aftercare service for Resident #1 on the porch along with his other personal items. In an interview on 4/27/2024 at 1:55 p.m. with Admissions Coordinator revealed she assisted with the discharge of the resident. Stated they wanted to ensure that the family was home. She stated someone did answer the door and stated the Admin. provided whoever answered the door the resident's medications. She stated when they got ready to leave whoever answered the door opened the door and threw the residents medications outside on the bench where the Resident #1 was sitting. She stated the resident tried to get up and walk away and stated their CNA A spoke with the resident in Spanish and advised him to continue to sit on the porch. She stated the Admin. called the police to complete a welfare check and stated she also called APS because someone, whoever was in the house did not allow Resident #1 to come into the home and closed the door. In an interview via phone on 4/27/2024 at 2:10 p.m. with BOM revealed they took the resident to RP1's house and stated they went to the door and a lady answered the door. Stated the Admin. spoke with the person who answered the door that this was the resident's medications, and this was the provider aftercare information. She stated the lady took the medication and closed the door, then she opened the door and started speaking in Spanish and threw the medications out on the bench. She stated before they were leaving the resident started walking down the driveway with his walker and stated they went back and talked with the resident about sitting in the chair and waiting for his daughter to come. She stated the other staff were speaking to him in Spanish because he does not speak English that good. She stated they unloaded his stuff and left it on the porch and stated they were not there that long. She stated she did not think that this person spoke English. Record review of facility discharge policy dated 11/28/2016 that reflected the following: The facility must discharge planning when you anticipate discharging a resident to a private home, another nursing facility or skilled nursing facility or any type, or another type of residential facility. The Admin was notified on 4/27/2024 at 3:40 p.m., An (IJ) Immediate Jeopardy was identified due to the above failures. The Admin was provided with the (IJ) Immediate Jeopardy template on 4/27/2024 at 3:40 p.m. , and a Plan of Removal (POR) was requested. (continued on next page)		

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The POR was accepted on 4/30/2024 at 3:32 p.m. The POR included the following: Problem: F660 Discharge Planning On 04/27/2024 an abbreviated survey was initiated at facility. On 4/27/24 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate Jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: 660: The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable Readmissions. The facility failed to ensure a safe discharge for Resident #1 when the facility dropped Resident #1 off at his RP1's home on the front porch unsupervised. The facility failed to ensure and coordinate the discharge of Resident #1 to RP1. The facility failed to ensure the completion of the discharge appeal process prior to discharging Resident #1 Interventions: 1. Resident #1 currently does not reside in the facility as of 4/27/24. Facility contacted family on 04/30/2024 and offered to return to facility. Family is pending decision to return. 2. The Administrator, DON, Admissions Coordinator, Social Worker, and Business Office Coordinator were in-serviced 1:1 by the [NAME] President of Clinical Services on 4/27/24 on the follow topics. Completed 4/27/24. a. Abuse and Neglect Policy b. Discharge Process Policy: Administrator will ensure a safe discharge in a safe environment with the family representative. Accommodation will be made with the RP prior to discharge during a care plan meeting. The resident will remain in the facility until the family has agreed to the services and care arranged for the discharge. c. Provider Letter/Discharge Appeal Process: A resident will not be discharged pending a discharge appeal. The resident will remain in the facility unless the resident/family agrees to a transfer or safe discharge. 3. The medical Director was notified of the Immediate Jeopardy on 4/27/24 by the Administrator. 4. An ADHOC QAPI meeting was completed with interdisciplinary team on 4/27/24 which included the medical director, Administrator, Director of Nursing, Social Worker, and Business Office Coordinator to discuss the citations and plan of removal. (continued on next page)		

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-services The Administrator and DON initiated the following in-services. Training began 4/27/24 and will be completed 4/28/24. 1. All staff were in-serviced on Abuse/Neglect and Discharge Process, including safe discharge and implementation of discharge plan. All staff not present will not work their next scheduled shift until in-serviced. All new hires will be in-serviced during facility orientation. All agency staff will in be serviced before working their assignment. Monitoring of POR on 4/29/2024 included the following: 2. Observation made on 4/29/2024 at 11:15 a.m. reflected a clean, homelike facility. Residents were up, out of their rooms, dressed and groomed appropriately for the weather. There were no foul odors present or soiled residents. Staff was observed assisting residents in the dining areas, answering call lights in a timely manner, and interacting with residents respectfully. The facility had a sufficient number of staff members to meet residents' needs. No environmental issues noted. 3. In an interview on 4/29/2024 at 11:20 a.m. the Admin stated she had completed 100 percent of in-service training with all staff including Aides and Dietary. The in-services included Abuse/Neglect, Discharge procedures and policy and Resident Property. The Administrator stated she was given one to one inservice by the [NAME] President of Clinical services. She stated knowledge of Abuse Neglect exploitation Policy. The Administrator stated the discharge of Resident #1 should have been accepted by a responsible family member. 4. In an interview on 4/29/2024 at 12:30 p.m. LVN A stated she received in-service education this morning on Abuse Neglect and Discharge Procedures. LVN A stated Abuse Neglect Policy included provisions for providing optimal care to improve a resident's health or living conditions. She stated a Resident must be discharged to a safe and responsible person after discharge planning. 5. In an interview on 4/29/2024 at 12:45 p.m. with Resident #10 stated he had no problems with staff at the facility. He stated they were always polite and kind to him. 6. In an interview on 4/29/2024 at 12:50 p.m. the ADON stated she had received in-service education on Abuse Neglect and Discharge Procedures. The ADON stated knowledge of the Abuse Neglect Policy, she stated staff were tested on knowledge, but she felt familiar with the policy. The ADON stated she received Discharge Planning and Discharge Procedures training, she stated the RP must accept discharged residents and state knowledge of their care needs and medication lists. 7. In an interview on 4/29/2024 at 12:55 p.m. with CNA G stated she had been in serviced on Abuse Neglect and Discharge Procedures. CNA G stated she was inserviced this morning as she had been off work. She stated failing to provide a safe secure environment for a resident would be an example of neglect. She stated the RP must receive a copy of the Discharge Plan and Medication list and understanding of the instructions for care should be checked. 8. In an interview on 4/29/2024 at 1:02 p.m. with Resident # 4, Resident # 7, Resident #8, and Resident #11 stated most staff were nice and that they had no complaints at this time. (continued on next page)		

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. In an interview on 4/29/2024 at 2:20 p.m. Med Aide A stated she worked the night shift. Med Aide A stated everyone had been in-serviced on Abuse Neglect, Dementia Care, Discharge Procedures, and Customer Service. Med Aide A stated she had worked with the Resident #1 and he took his medications without any problems. The Med Aide A stated knowledge of Abuse Neglect policy, she stated a resident must be provided a safe secure environment and care as needed to avoid neglect. Med Aide A stated discharge planning should include a list of medications, instructions for their administration and a daily schedule. 10. In an interview on 4/30/2024 at 3:38 p.m. the Admin stated she had spoken to the family of Resident #1 today (4/30/2024) and they were still considering their options. She stated the family was still appealing Resident #1's discharge and there was a hearing scheduled for 5/29/24, she stated she was notified of the hearing date today. 11. Record review of facility's abuse and neglect policy revealed the policy included the key components of screening, training, prevention, identification, investigation, protection and reporting alleged incidents of abuse, neglect, and exploitation/misappropriation. 12. Record review of facility's discharge policy revealed the policy included key components of the discharge process. On 4/30/2024 at 4:05 p.m., the Admin was informed the (IJ) Immediate Jeopardy was removed. While the (IJ) Immediate Jeopardy was removed on 4/30/2024 at 4:05 p.m., the facility remained out of compliance at a scope of isolated and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy.		