

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

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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 09/05/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49851 Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain functional abilities for 1 (Resident #3) out of 7 residents reviewed for ADLs. The facility failed to ensure Resident #3 was placed in a safe and comfortable position while eating. This failure placed the resident at risk of discomfort and choking/aspiration. Findings included: Review of Resident #3's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of unspecified fracture of left femur, multiple sclerosis (a disease which causes nerve damage and disrupts communication between the brain and the body), dysphagia (difficulty swallowing), and cognitive communication deficit (communication impairment causing trouble reasoning and making decisions while communicating). Review of Resident #3's comprehensive MDS, dated [DATE], reflected a brief interview for mental status (BIMS) score of 10 indicating moderate cognitive impairment. MDS reflected Resident #3 was dependent on assistance with lying to sitting and sitting to lying position change. Review of Resident #3's Care Plan, dated 06/22/2024, reflected the resident had an ADL Self Care Performance Deficit and required staff assistance with bed mobility. The care plan reflected the resident received tube feedings with a history of dysphagia and risk for aspiration (occurs when contents such as food, drink, saliva enter the lungs). Observation of video recorded at 07/15/2024 at 08:39 AM revealed Resident #3 lying in bed eating breakfast with the head of the bed slightly elevated. He was observed trying to lift his head off the pillow and struggling to see his food and eat while lying down. No observation of choking noted. In an interview on 09/03/2024 at 11:20 AM the RP for Resident # 3 stated she was concerned about the position Resident #3 was placed in while eating sometimes. She stated she had spoken with the Administrator and the staff regarding Resident #3's history of difficulty swallowing and the need for him to be raised to as close to 90 degrees as possible for meals due to the risk of choking. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/05/2024 at 9:25 AM Resident #3 stated he preferred to sit up when eating his meals and the staff sometimes sit him all the way up, but not always. He stated it was difficult to eat and see his food while lying down . In an interview on 09/05/2024 at 10:25 AM CNA A stated residents should be sitting up right while eating or with the head of the bed elevated to prevent choking. In an interview on 09/05/2024 at 10:30 AM LVN C stated residents should be sitting up at about 90 degrees while eating due to the risk for aspiration/choking and to increase digestion and absorption. In an interview on 09/05/2024 at 10:45 AM MA D stated residents should be in an upright position while eating to prevent choking. In an interview on 09/05/2024 at 11:06 AM the ADON stated residents should be in high [NAME] position (head of bed elevated between 60-90 degrees) to eat, if tolerated, and preferably in a chair. She stated the resident needs to sit up while eating due to the risk for choking. She stated the position of Resident #3 in the video did not look safe and you can see him struggling to see his food and lift his head to eat. She stated she completed an in-service on the importance of sitting up and eating after viewing the video of Resident #3. In an interview with the Administrator and the AIT on 09/05/2024 at 11:15 AM, the Administrator stated Resident #3 did not look comfortable while trying to eat in the video. The AIT stated the position was a safe position and the resident often stated he did not want the head of the bed raised any more than what was shown in the video. They both stated the importance of respecting resident wishes. Review of an in-service on residents eating meals in their beds, dated 07/18/2024, reflected staff were trained to ensure the residents were sitting up as high in bed as they could tolerate during mealtimes. Training reflected staff were educated on the purpose of sitting up while eating including to lessen the risk of choking, the residents are able to feed themselves better, the residents can enjoy their meals as they can see what they are eating, and it helps aid in digestion.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49851 Based on observations, interviews, and record review, the facility failed to 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 one (Resident #3) out of five residents reviewed for infection control. 1. The facility failed to ensure staff wore PPE while providing care for Resident #3. 2. The facility failed to ensure staff followed the facility policy and tied back long hair to minimize cross contamination. These failures placed the residents at risk of cross contamination and infection. Findings included: Review of Resident #3's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of unspecified fracture of left femur, multiple sclerosis (a disease which causes nerve damage and disrupts communication between the brain and the body), dysphagia (difficulty swallowing), and cognitive communication deficit (communication impairment causing trouble reasoning and making decisions while communicating). Review of Resident #3's comprehensive MDS, dated [DATE], reflected a brief interview for mental status (BIMS) score of 10 indicating moderate cognitive impairment. MDS reflected Resident #3 was dependent on assistance with bed mobility, toileting, and bathing. Review of Resident #3's Care Plan, dated 06/22/2024, reflected resident was on enhanced barrier precautions (EBP) and gown and gloves should be worn during linen change, resident hygiene, transfers . with a goal of no transmission of infection from or to the resident. 1.Observation of video recorded on 08/24/2024 at 8:00PM revealed a staff member (unidentified) in Resident #3's room pulling back the linens and touching the resident's diaper without wearing the proper PPE as required for a resident on EBP. In an interview on 09/05/2024 at 09:25 AM Resident #3 stated the staff usually wear gowns when they provide care, but not always. In an interview on 09/05/2024 at 10:25 AM CNA A stated he was trained on EBP and contact precautions. He stated residents with open wounds or with a catheter are on EBP and staff need to wear a gown when providing care, because we don't want to get anybody sick. In an interview on 09/05/2024 at 10:30 AM LVN C stated EBP should be used for a resident that has anything that could cause an infection. She stated staff should wear PPE to try and prevent the spread of infection. She stated PPE should be worn while providing ADL care when a resident has a wound or a catheter. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/05/2024 at 10:35 AM MA D stated EBP was used for anything to do with a catheter or anything with secretions. She stated PPE should be worn for residents with a PEG tube or a foley catheter. She stated PPE was worn for protection from fluids and splashing. In an interview on 09/05/20204 at 11:06 AM the ADON stated EBP was used for residents with infections or isolation and should be used for residents with wounds and indwelling lines or catheters. She stated gowns and gloves should be worn in the room while providing care and proper hand hygiene should be done to prevent cross contamination and infection. In an interview with the ADM and the AIT on 09/05/2024 at 11:15 AM the AIT reviewed the facility policy and stated EBP should be used when transferring a resident in bed and during linen changes as seen in the videos due to the risk for infection. Review of facility policy on EBP, date unknown, reflected PPE should be worn during high-contact resident care activities for residents with a chronic wound or indwelling medical device. Review of in-service on 07/09/2024 reflected staff were trained on EBP and when to wear PPE. 2. Observation of video recorded on 08/21/2024 at 11:17 AM revealed HK supervisor and CNA B in Resident #3's room providing care. HK supervisor was seen gathering dirty linens on the floor. Her long hair/braids were not tied back and touched the dirty linens and the floor. Observation revealed both staff members without gowns despite the resident being on EBP. In an interview on 09/03/2024 at 2:10 PM RN E stated long hair should be tied back while providing care due to the risk of infection for the residents. In an interview on 09/05/2024 at 10:45 AM HK supervisor stated her long hair may touch dirty things at times. She stated, in reference to the video you're talking about, I was just helping the nurse because she asked for help . In an interview on 09/05/2024 at 11:06 AM the ADON stated long hair should be put up for infection control concerns as it could touch contaminated objects and then touch the residents. She stated she would expect staff to keep hair tied back. In an interview on 09/05/20204 at 11:06 AM the ADM and AIT stated the long hair touching the dirty linens and the floor as seen in the video was an infection control concern due to the risk of cross contamination. Review of facility policy on dress code/grooming, dated 09/20/2019, reflected employees providing direct resident care must keep hair pulled back.		