

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 01/17/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, clean, comfortable, and homelike environment for 1 (Resident #1) of 4 residents reviewed for environment. The facility failed to ensure Resident #1's room was free of odor and soiled sheets. This failure placed residents at risk of living in an uncomfortable environment leading to a diminished quality of life. Findings included: Record review of Resident #1's face sheet, dated, 01/17/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included Parkinson's disease without dyskinesia, without mention of fluctuations (a progressive movement disorder of the nervous system. Dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs, or trunk)), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a decline in mental ability that affects memory, thinking, and behavior), adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, decreased appetite, poor nutrition, inactivity, and often accompanied by depression, cognitive decline and, functional impairments). Record review of Resident #1's Quarterly MDS Assessment, dated 12/06/2024, reflected the resident had a BIMS score of 7, which indicated his cognition was severely impaired. Resident #1 required substantial/maximal assistance (helper does more than half the effort) with the following: toileting hygiene, showers, lower body dressing, and personal hygiene. Resident was always incontinent of bowel and bladder. Record review of Resident #1's Comprehensive Care plan, dated 12/06/2025, reflected Resident #1 had an ADL self-care performance deficit. Intervention: Bathing, toileting, and dressing: Resident #1 required one staff assistance. Resident #1 required assistance with personal hygiene as needed. (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

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 01/17/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/16/2025 at 8:55 AM revealed Resident #1 were lying in bed. There was a strong urine odor beside Resident #1's bed. Resident #1's sheets were partially wet and partially dried with urine. The urine odor was stronger near the resident. Resident #1 did not respond to any questions or conversations. Resident #1 would open and close his eyes during visit and covered his head with the bedspread. Observation and interview on 01/16/2025 at 9:40 AM revealed Resident #1 was lying in bed. There was a strong urine odor beside Resident #1's bed. Resident #1's sheets were dried with urine odor and beginning to make a stain on the sheets. Interview on 01/16/2025 at 10:00 AM with CNA A revealed she did smell a strong urine scent in Resident #1's room. CNA A stated part of the sheet was wet and part of the sheet the urine was dried. CNA A stated she was not assigned to Resident #1 and she worked on another hall. She stated she did not know who was assigned to Resident #1's room. CNA A stated staff made rounds on residents every 2 hours. She stated began making rounds at 7:00 AM and rounds was expected to be made by 9:00 AM. CNA A stated I that was when she made her rounds. She stated she would report this to someone. Interview on 01/16/2025 at 10:10 AM with CNA B revealed she was assigned to the same hall where Resident #1 resided, and she checked on him between 9:10 AM and 9:30 AM. She stated she did not recall if there was a urine odor in room or if his sheets were wet. CNA B stated she had taken care of several residents and did not recall the circumstance with Resident #1. She did not respond when asked if she had changed Resident #1. In an interview on 01/16/2025 at 11:45 AM, the Director of Nurses stated all staff was expected to make rounds every 2 hours. She stated if any resident had a urine odor on their sheets, the CNA was expected to change the sheet immediately and place new sheets on the bed. The Director of Nurses stated the resident was expected to be changed immediately. Record review of the facility's Policy of Resident Rights, revised on 11/28/2016, reflected the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.		

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 01/17/2025
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interview and record review , the facility did not ensure prompt efforts were made to document a resident grievance for one (Resident #2) of four residents reviewed for grievance resolutions. The facility failed to promptly document grievances regarding answering call lights and begin an investigation. This failure placed resident at risk of not having their grievances resolved. Findings included: Record review of Resident #2's face sheet, dated, 01/17/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included chronic obstructive pulmonary disease, unspecified (a long- term lung disease that makes it hard to breathe), polyneuropathy, unspecified (a condition that occurs when nerves are damaged, causing problems with sensation, coordination, and other body functions), and morbid obesity with alveolar hypoventilation (a severe form of obesity that can be life-threatening. Record review of Resident #2's Admission MDS assessment, dated 12/13/2024, reflected the resident had a BIMS score of 15, which indicated his cognition was intact. Resident #2 required partial to moderate assistance (helper does less than half the effort) with toileting hygiene, and showers. Resident #2 required supervision or touching assistance with upper and lower body dressing, toilet transfers, and personal hygiene. Record review of Resident #2's Comprehensive Care Plan, with target date of 2/18/2025, reflected Resident #2 had an ADL self-care performance deficit. Interventions: Toilet use: Resident #2 required assistance (wash hands, adjust clothing, clean self , transfer onto toilet, transfer off toilet) to use toilet. Encourage Resident #2 to use bell (call light) to call for assistance. Encourage Resident #2 to discuss feelings about self-care deficit. Transfers: supervise Resident #2 as needed. Resident #2 was at risk for falls related to balance problems. Interventions: Anticipate and meet the resident's needs. Encourage Resident #2 to use the call light for assistance. (continued on next page)		

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 01/17/2025
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/16/2025 at 9:45 AM, Resident #2 stated he assisted himself to the bathroom and this was normal for him to assist self on the toilet. He stated he usually could clean himself when he urinated. However, he was not capable of cleaning himself when he had a bowel movement. Resident #2 stated he used the call light to get assistance with cleaning himself after he had a bowel movement yesterday (1/15/2025). He stated he waited at least forty-five minutes or more before any staff came to his room. Resident #2 stated while he was on the toilet, he called the complaint into state about the call light not being answered. He stated he also called the Director of Nurses and asked her to write a complaint about him having to wait on the toilet for forty-five minutes or more before someone answered his call light. He stated the Director of Nurses stated she would investigate his complaint about the call light beginning that day (01/15/2025). Resident #2 stated he asked her twice to write a complaint about the call lights and he stated the Director of Nurses stated she would write the complaint that day (01/15/2025). Resident #2 stated there were times he had voiced a complaint, and no one wrote it down on any paper. He stated that was why he called the state to voice his concern due to feeling his concern would not be documented or investigated. Record review of the facility's grievance's records from residents and families reflected Resident #2's grievance on 01/15/2025 had not been documented. In an interview on 01/16/2025 at 11:45 AM, the Director of Nurses stated Resident #2 called her on the phone on 1/15/2025 and requested a complaint be written about him having to wait about forty-five minutes before staff answered his call light. She stated she informed Resident #2 she would write a grievance and investigate his complaint. The Director of Nurses stated anytime a resident or family member voiced a grievance it was to be documented immediately and begin the investigation the day the complaint was voiced to any staff. She stated she was expected to write a grievance on 1/15/2025. In an interview on 01/16/2025 at 2:45 PM, the Director of Operations stated anytime a resident or family member voiced a grievance, the staff was expected to write the grievance the time it was voiced to them or report it to someone in administration for them to write an official grievance on the companies' grievance form. She stated either the person received the grievance would investigate it or delegate the investigation to appropriate staff according to the grievance. She stated if it was related to call lights the Director of Nurses would be responsible to investigate the call light grievance. The Director of Operations stated if a grievance was voiced to the Director of Nurses on 01/15/2025, she was expected to document the grievance and begin investigation on 01/15/2025. Record review of the facility's policy on Grievances, revised on 11/02/2016 reflected all written grievances decisions will include: 1. The date the grievance was received. 2. A summary statement of the resident's grievance. 3. The steps taken to investigate the grievance. 4. A summary of the pertinent findings or conclusions regarding the resident's concern(s). 5. A statement as to whether the grievance was confirmed or not confirmed. (continued on next page)		

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

Printed: 03/27/2025
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 01/17/2025
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Any corrective action taken or to be taken by the facility as a result of the grievance. 7. The date the written decision was issued.		

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 01/17/2025
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 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. 40884 Based on observation, interview, and record review, the facility failed to store, prepare, distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation. The facility failed to ensure [NAME] C properly used proper hand hygiene during food preparation. This failure could place residents who ate food from the kitchen at risk for foodborne illness. Findings included: Observation on 01/16/2025 between 10:45 AM and 11:15 AM, [NAME] C was preparing residents' lunch meal. She was not wearing gloves when she was stirring food in pots on the stove. [NAME] C exited from the stove area and pushed a utility kitchen cart from the stove area located in front of the kitchen to the area back of the kitchen. [NAME] C touched her clothes and adjusted her hair net prior to picking up gloves from the container. [NAME] C did not wash or sanitize her hands prior to picking up the fourchettes (a component of the glove where the fingers fit into the glove) on the gloves with her fingers on both hands. [NAME] C proceeded to put her right hand into chicken bouillon powder and placed it in a container. [NAME] C exited the back of the kitchen into the front of the kitchen where the stove was located. She placed the bouillon into a pot on the stove. [NAME] C discarded the gloves and did not wash or sanitize her hands. [NAME] C touched her clothes and picked up a large pot. [NAME] C's middle, ring, and fore fingers on her right hand (from the knuckle to the tip of her fingers) touched inside of the pot. [NAME] C did not take the pot into the dirty dishwasher room after using the pot. She placed the pot back on the bottom shelf. [NAME] C exited the front of the kitchen and entered the back of the kitchen where she obtained a plastic bag of food. [NAME] C did not wash or sanitize her hands between tasks. She touched the outside of plastic bag with her bare hands. She placed her right hand into the bag and picked up pasta and placed pasta into the pot on the stove. [NAME] C touched inside the curved area in a large ladle with her bare hands. [NAME] C never washed or sanitized her hands the entire time she was being observed in the kitchen. [NAME] C washed her hands when surveyor was getting ready to leave the kitchen area. The Dietary Manger asked her to wash her hands. In an interview with the Director of Operations on 01/16/2025 at 11:20 AM (she was in the kitchen with surveyor during observation) stated she observed that [NAME] C did not wash or sanitize her hands during the entire kitchen observation on 01/16/2025. She stated [NAME] C was expected to sanitize or wash hands between tasks and before touching food. The Director of Operations stated [NAME] C cross contaminated the food when [NAME] C touched the food with her bare hands. The Director of Operations stated she agreed with everything the surveyor observed in the kitchen. (continued on next page)		

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 01/17/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/17/2025 at 1:15 PM, [NAME] C stated she did not wash or sanitize her hands prior to placing gloves on her hands and in between tasks. She stated she touched her clothes and the handle of the utility cart. [NAME] C stated her clothes and the handle of the utility cart would be considered contaminated. She stated after she touched those items, she did not sanitize or wash her hands. [NAME] C stated there was a possibility she contaminated the food. She stated a resident may become ill such as stomach issues such as vomiting if the residents ate food with bacteria. [NAME] C stated she received an in-service on hand hygiene. She stated she did not recall the date or time of in-service. In an interview on 01/17/2025 at 1:30 PM, the Dietary Manager stated she expected the dietary staff to wash their hands especially when the staff touched raw food such as chicken and touched other food. She stated staff was expected to wash their hands when the staff changed tasks in the kitchen. Dietary Manager stated yes when asked if she instructed Dietary Manager to wash her hands after approximately 20 minutes of surveyor observing [NAME] C in the kitchen. She stated dietary staff received in-services on Relias computer system. Dietary in-services were requested prior to 01/16/225 from the Dietary Manager and this was not provided at time of exit. Record review of the facility's Hand Washing Policy, dated 2012, reflected we will ensure proper hand hygiene procedures are utilized. Employees are too frequently perform hand washing.		