STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676019	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lampstand Nursing and Rehabilitation	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on observations, interviews, and record reviews, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access, for 1 Resident (Resident #1) of four residents reviewed for medication storage, in that: A bottle of Nystatin Topical Powder was found on 04/24/25 at 12:55 pm left unattended and unsecured at Resident #1's bedside. This deficient practice placed residents at risk for unauthorized access, drug diversion, or ingestion of medications leading to harm. Findings included: Review of Resident #1's face sheet dated 0414/25 reflected a [AGE] year-old female admitted to the facility on [DATE]. She had diagnoses of diabetes mellitus Type 2 (a chronic condition where the body either doesn't produce enough insulin, or the cells don't properly respond to the insulin produced, leading to elevated blood sugar levels), mild cognitive impairment, disorder of pituitary gland, and obesity. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating intact cognition. Review of Resident #1's care plan reflected a focus dated 07/19/2022 that Resident #1 had a potential for pressure ulcer development with an intervention of administer medications as ordered. Review of Resident #1's order dated 04/03/15 reflected Nystatin Powder (a topical antifungal medication used to treat fungal skin infections, particularly those caused by Candida albicans (a naturally occurring fungus that lives on your body) and available by prescription only) apply to affected area topically every 24 hours as needed for yeast and apply to affected areas topically one time a day for yeast rash for 10 days. Observation on 04/24/25 at 12:55 pm revealed a bottle of Nystatin Topical Powder, USP 100,000 USP Units Per Gram on Resident #1's bedside table. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/25 with Resident #1 at 12:55 pm reflected she said she had an order for the two medications to be left bedside. Interview on 04/24/25 with LVN A at 4:30 pm revealed she was Resident #1's nurse that day, and she worked the 6:00 am until 6:00 pm shift. She stated she was not aware of the Nystatin Topical Powder at Resident #1's bedside, and she did not know how the medications got there. She stated the negative effects of leaving medications in a resident's room was that someone could pick up the medications and, anything could happen. She said children could walk in and take the medications. She said that she felt sure Resident #1 would not have touched the medications, and Resident #1 would wait for staff to administer the medications. Interview on 04/24/25 with ADON LVN at 3:35 revealed she had worked with Resident #1, and she was not aware that Resident #1 had Nystatin Topical Powder by her bedside. She revealed that the facility did not allow any medications to be at residents' bedsides. She said it was the responsibility of the charge nurse to make sure no medications were at resident's bedside, but it should be everyone's responsibility if they see a medication by a residents' bedside to grab it and return it to where it belongs. She revealed the negative effect of leaving medications by a residents' bedside was that someone who had dementia could get confused and might try to drink or eat the medication. She revealed that if the resident used the medication, without the staff's knowledge, the nurse would not know how much medication the resident might have used or consumed. Interview on 04/24/25 with RN B at 3:10 pm revealed ordered medications should not be left in a resident's rooms, and she did not know there were medications left by Resident #1's bedside. She said it was against policy for both over the counter and prescribed medications to be left out in a resident's room. She said the negative effects could be that medications must be taken in accordance with the doctor's orders, and if they were left out, they did not know if a resident had taken the medication, and it could impact the resident's health negatively. Interview on 04/24/25 with the DON 4:26 pm revealed she found the Nystatin Topical Powder in Resident #1's room after the surveyor asked her about it. She stated it was not facility policy to have any medications left in a resident's room and she removed the medication. She revealed it was the responsibility of the nurses to make sure there were no medications left in a residents' room and the negative effect of leaving medications in a residents' room was they could use the medication and receive the incorrect dosage, and it might cause the resident harm. Review of the facility's Medication Administration Procedures dated 10/25/17 reflected all medications are administered by licensed medical or nursing personnel. The facility had no policy that addressed medicaitons at residents bedside.