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	10/10/2025

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the legal surrogate so designated may exercise the resident's rights to the extent provided by state law for 1 of 7 (Resident #1) residents reviewed for resident rights. The facility failed to ensure that LVN F did not care for Resident #1 on 10/08/2025 and 10/09/2025 after the RP told him to leave the room and not care for Resident #1 after 10/08/2025 at 7:32AM. This failure couple place residents whose rights are exercised through a legal representative at risk of not having their rights exercised.Findings Include: Record Review of Resident #1's Facesheet printed on 10/08/2025 revealed a 37 y/o male, admitted to the facility on [DATE]. Diagnoses included unspecified convulsions, schizophrenia, weakness, and personal history of traumatic brain injury (TBI). Record review of Resident #1's admission MDS, dated [DATE], reflected no BIMS score. Section GG -Functional Abilities - admission section reflected Resident #1 was categorized as dependent on staff for all forms of mobility that could be safely assessed at that time. Record review of Resident #1's Care plan, dated 10/08/2025, reflected a Focus area stating, The resident is risk for falls r/t Gait/balance problems, Incontinence, Poor communication/comprehension Date Initiated: 09/12/2025 with Interventions/Tasks stating, Anticipate resident's needs. Date Initiated: 09/12/2025. Additional Focus area stating, The resident has an ADL Self Care Performance Deficit Date Initiated: 09/12/2025, with Interventions/Tasks stating, Bed Mobility: requires staff x2 for assistance Date Initiated: 09/12/2025. Observation of Resident #1 on 10/08/2025 at 10:00AM revealed he was sitting in the lobby area, watching television with several other residents. He was well groomed. He wore non-skid socks, pants, and a shirt. He was lying, with the head of the chair partially raised, in a geri-chair. He had a fleece blanket over his body. He smiled when spoken to but did not respond. In an interview with LVN F on 10/08/2025 at 11:06AM, he stated that the RP kicked him out of the room that morning, We had to get other aides to help me. Not sure of staff who are listed. She is running out of people that she will let care for him. He stated he was not restricted from being Resident #1's nurse. He stated the RP told me to get out. He stated he could not hear all of what was said by the RP, but he had heard something about social media. He stated the RP kept making social media posts about him. He stated it was frustrating trying to care for Resident #1 when the verbally aggressive behavior and accusations made by Resident #1's RP. He stated Resident #1 was getting good care and that was his focus. Observation of video evidence provided by the Admin in an email on 10/9/2025 at 10:54AM, revealed a time stamped video dated 10/08/2025 at 7:32AM. LVN F and CMA D were visible through a camera in Resident #1's room. CMA D brought in a mechanical lift device and began speaking with Resident #1. She offered a drink and informed him they would be getting him up. LVN F was at the bedside for Resident #1. A voice was heard through the camera stating that LVN F should not be working with Resident #1. LVN F stopped and asked, What? and Who? to the camera. The voice requested again that he leave the room and not care for Resident #1 because he viewed her social media account. LVN F then walked out of the room. In an interview with RNC and Admin on 10/09/2025 at 11:24AM, the RNC stated she was not aware of any restrictions regarding LVN F's ability to care for Resident #1. He will be removed from any future assignments. The Admin stated neither the RP nor the staff informed her that staff were caring for Resident #1 after she informed them not to. Notify the staff after request to remove from care and then they know they don't assign them to that room. If they are informed by a family member not to care for them, they should directly report that to the administrator. LVN F did not report to me that he was told not to care for them. She stated if an RP or a resident requested not to have a staff member care for them, then they do not allow the staff to come in the room again if their care was refused. She stated when a resident or an RP informs the staff that a person was no longer allowed to care for them, we inform the Staffing Coordinator/ ADON and the staff member of the changes. She stated she would look at the assignment sheet for 10/09/2025. She stated the staffing assignment was made prior to the notification in the video on 10/08/2025. She stated they had no notification before that, that LVN F was not allowed to care for the resident. In a phone interview with LVN F on 10/09/2025 at 11:49AM, he stated he did go back in the room to care for Resident #1 around 1:30PM on 10/08/2025 after being told not to care for him by the RP through the camera. He stated he was in there because an aide put him to bed and did pericare, so I did oral care for him while was there. He stated he did not change assignments after the RP told him not to care for Resident #1. He stated She has said that to everyone to the point and now there aren't enough people to go in and care for him. He stated he

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the care and supervision to prevent accidents for 1 of 7 (Resident #1) residents reviewed for accidents and hazards. The facility failed to ensure that Resident #1 was repositioned with two-person assist and left in an unsafe position when CNA A walked away from the bedside on 9/15/2025. The noncompliance was identified as Past Noncompliance (PNC). The IJ template was provided to the facility on [DATE] at 1:25PM. The IJ began on 9/12/2025 and ended 9/15/2025. The facility corrected the noncompliance before the survey began on 10/08/2025. This failure placed residents at risk for accidents, falls, fractures, and diminished quality of life.Findings Include: Record Review of Resident #1's Facesheet dated 10/08/2025 revealed a 37 y/o male, admitted to the facility on [DATE]. Diagnoses included unspecified convulsions, schizophrenia, weakness, and personal history of traumatic brain injury (TBI). Record review of Resident #1's admission MDS, dated [DATE], reflected no BIMS score. Section GG -Functional Abilities - admission section reflected Resident #1 was categorized as dependent on staff for all forms of mobility that could be safely assessed at that time. Record review of Resident #1's Care plan, dated 10/08/2025, reflected a Focus area stating, The resident is risk for falls r/t Gait/balance problems, Incontinence, Poor communication/comprehension Date Initiated: 09/12/2025 with Interventions/Tasks stating, Anticipate resident's needs. Date Initiated: 09/12/2025. Additional Focus area stating, The resident has an ADL Self Care Performance Deficit Date Initiated: 09/12/2025, with Interventions/Tasks stating, Bed Mobility: requires staff x2 for assistance Date Initiated: 09/12/2025. Record review of Resident #1's Progress Notes dated 10/08/2025 reflected no falls since his admission on [DATE]. Observation of Resident #1 on 10/08/2025 at 10:00AM revealed he was sitting in the lobby area, watching television with several other residents. He was well groomed. He wore non-skid socks, pants, and a shirt. He was lying, with the head of the chair partially raised, in a geri-chair. He had a fleece blanket over his body. He smiled when spoken to but did not respond. Observation of video on 10/9/25 (no time/date stamp), revealed Resident A lying on the bed wearing only a brief, with only a fitted sheet on the bed and his body fully exposed. There are fall mats on both sides of the bed. The bed was in a raised position. Both of his feet are hanging off the left side of the bed. CNA A was standing on the left side of the bed. She attempted to move his feet into the bed, but they bumped the footboard of the bed and moved back to their position off the bed, due to the rigidity of his muscles. She walked to the right side of the bed at the head of the bed and attempted to use the sheet beneath him to pull him up in the bed. The pulling motion resulted in Resident #1 being in a diagonal position with his head on the top, right edge of the bed and his legs positioned off the bed to the level of his knee on his left leg and his foot on the right leg. She attempted to turn Resident #1 on his left side but the resident became more rigid and resisted the movement toward the right side of the bed. She walked to the left side of the bed and tried to push the residents' legs in the bed, assisting him to bend his knees, and rolled him on his right side, holding his body with one hand, she adjusted his brief with the other hand. She then assisted Resident #1 to lay on his back, and due to his muscle tension, his legs and torso moved to being in a position with both legs off the bed up to his knees on the left side of the bed, and in a diagonal position with his head on the edge of the top, right side of the bed. His brief was unfastened on his right side from the movement. CNA A stated, I can't be doing this all day. CNA A walked away from the bedside toward the door. Observation on 10/10/2025 of Video dated 9/15 at 9:41:15 AM revealed CNA A with Resident #1. Resident #1 is lying in bed on his right side with CNA A on the right side of the bed. The bed was in a raised position with fall mats on both sides of the bed. The resident was wearing a brief with no sheets covering his body. The video fast forwards to Resident #1 laying in a diagonal position across the bed with his legs hanging off the bed up to his knees and his head at the top, left edge of the bed. At the time stamp 9:41:31 AM it continued at normal playing speed, CNA A, still standing on the right side of the bed, walked away from Resident #1's bedside and was heard saying, I can't be doing this all day as she walked to the door. She left the room at 9:41:35 AM. Resident #1's call light was not in reach. The cord can be seen at the top right of the headboard. CNA A returned to the room at 9:42:37 AM with a female staff member. The video cut off momentarily and returned at time label, 9/15 9:42:44 AM. CNA A was standing in front of the cabinet with the camera. The camera view was slightly lower than the previous view. The head of the bed was no longer visible. CNA A and a second staff member (name tag not visible in the video) put on Resident#1's shirt and shorts. CNA A stated, He's a fall risk. Two staff members reposition Resident #1 into

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure residents were free from significant medication errors for 1 of 7 (Resident #1) residents reviewed for pharmacy services. The facility failed to ensure that Resident #1 was provided pharmacy services to ensure that he did not have a preventable seizure on 9/14/2025 at 8:10AM. The noncompliance was identified as Past Noncompliance (PNC). The IJ template was provided to the facility on [DATE] at 1:25PM. The IJ began on 9/12/2025 at 11:22PM and ended 9/15/2025. The facility corrected the noncompliance before the survey began on 10/08/2025. This failure placed residents at risk for seizures, hospitalization and death.Findings Include: Record Review of Resident #1's Facesheet dated 10/08/2025 revealed a 37 y/o male, admitted to the facility on [DATE]. Diagnoses included unspecified convulsions and personal history of traumatic brain injury (TBI). Review of Resident #1's admission MDS, dated [DATE], reflected no BIMS score, indicating the resident was unable to complete the assessment. Resident #1was categorized as severely impaired regarding his cognitive skills for daily decision making and reflected that he was rarely or never understood. Review of Resident #1's Care plan, dated 10/08/25, reflected a Focus area stating, The resident has a seizure disorder Date Initiated: 09/12/25 and Interventions/Tasks that reflected, Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness of medications. Date Initiated: 09/12/25. Record review of Resident #1's Internal Medicine Discharge summary dated [DATE] and signed by MD C reflected Resident #1 had a seizure at the facility he was at prior to admission. It reflected he was started on Keppra and no further seizure activity was noted after that time.Record review of Resident #1's Medication Administration Record (MAR) printed on 10/08/2025 revealed, and order for Keppra Oral Tablet 500 mg (Levetiracetam) Give 1 tablet by mouth two times a day related to UNSPECIFIED CONVULSIONS. Two of three opportunities to administer Keppra were not administered during the time period starting from the PM dose on 9/12/25 and ending before the AM dose on 9/14/2025 as follows: . *The PM dose on 09/12/2025 is recorded as a 9 by RN A. *The PM dose on 09/13/2025 is recorded as 2 by CMA D. * The order was discontinued on 09/14/2025 at 4:45PM. Further review revealed the legend indicated, 9=Other / See Nurse Notes and 2=Drug Refused. Record review of Resident #1's Progress note dated 09/12/2025 at 11:22PM and signed by RN A reflected the Note Text for the Keppra Oral Tablet 500 mg medication administration stated, unable to arouse resident with verbal and tactile stimuli enough to safely swallow. Record review of Resident #1's Progress note dated 9/13/2025 at 6:16PM signed by CMA D reflected the Note Text for the Keppra Oral Tablet 500 mg medication administration stated, Resident would not open his mouth and kept pressing his lips tightly. Record review of Resident #1's Progress note dated 09/14/2025 at 08:10AM and signed by Weekend Supervisor, reflected, Nsg (nursing) notified by assigned CNA that she had changed the resident's brief; repositioned him. CNA then noted the patient to turn red in the face; mucous appearing drool from the left side of his mouth; BUE extended and stiff; eyes closed; pt (patient) not responsive to verbal or painful stimulation at that time. VS (vital signs) noted to be 116/72 pulse 89 and respirations 27; pulse oximetry on room air was 99%. Pt (patient) noted to have history of Seizure Disorder. Pt (patient) safety maintained at all times. Noted length of active seizure activity was apprx (approximately) 2-2.5 minutes. Pt (patient) then noted to be postictal (the recovery phase after a seizure); eyes remained closed; BUE (bilateral upper extremities) noted to be relaxed; skin color WNL and patient appears relaxed. Staff remained at bedside0819 hrs - Weekend RN notified the DON of event0829 hrs - Weekend RN contacted the [RP] and she requested he be sent to the ED for further evaluation. [RP] stated that she was aware of his last Seizure being on 6/26/2025. 911 was contacted; pt being sent to [ED]. Record review of Resident #1's a Late Entry Event note dated 09/14/2025 at 12:00PM signed by DON, reflected [RP] upset because resident did not get 2 doses of his medication and she was not informed Initial Treatment/New Orders: Keppra Level q (every) 3 months. Resident Statement: NAName of MD/NP notified: [NP] Date/time of notification: 09/14/2025 12:00 PM.Name of RP notified: [RP] Date/time of notification: 09/14/2025 2:00 PM.Interventions: NA Record review of Resident #1's Hospital records dated, 09/14/2025, revealed -LAB RESULTS on 09/14/2025 at 09:22AM reflected a Levetiracetam level of (B) indicating a level of less than 0.2 ug/mL (micrograms per milliliter). Record review of Resident #1's Discharge Instructions from hospital dated 09/14/2025 at 10:48AM reflected Special Instructions stating, The patient's blood work showed an undetectable Keppra level which would imply that he is either not receiving it or no longer is been prescribed it. If the patient has a prescription or