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	12/04/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 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 observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #1) of 5 residents observed for pharmacy services.The facility failed to assure Resident #1 was aware of the medications that he was administering. This failure could affect residents receiving medications by placing them at risk for medication errors. Findings included:Review of Resident #1's MDS assessment, dated 12/4/2025, reflected he was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses that included unspecified convulsions (A seizure occurs due to an electrical disturbance in the brain, while a convulsion describes the involuntary action of jerking and contraction), schizophrenia, unspecified (a serious mental health condition that affects how people think, feel and behave), weakness (the state or condition of lacking strength), personal history of traumatic brain injury (an injury to the head that affects the way the brain works). Resident #1 BIMS score is 00 which is sever impairment. Review of Resident#1 Care Plan reflected the resident has impaired cognitive function/dementia or impaired thought process, a communication process (mostly non-verbal), he has as ADL Self Care performance deficit. The goal is for the residents to maintain current level of cognitive function through the review date. He will make basic needs known by (gestures, sounds, staff anticipating needs) daily through the review date. Interventions are for staff to monitor, document and report any changes. Review of Resident #1's Physician order, signed and dated by the physician on 9/12/2025, reflected Keppra Oral Solution 100 MG/ML (Levetiracetam) was ordered to be given twice a day for convulsions. This medication is what Resident #1 was provided when the Med Aide did not advise him what she was administering.Observation of video footage of Resident #1 on 11/26/25 at 7:15 PM revealed he was lying in bed with his hands behind his head and the bed was elevated. He was awake and alert. Med Aide knocked on the door and entered the room saying hello twice and advised the resident she had medication for him. She bent over to give the medication to Resident #1 and made sure he swallowed the medication. She asked Resident #1 are you okay? Resident #1 was non-verbal, so no response was heard. Per the Care Plan, the BIMS score and an attempt for an interview with the resident determined Resident #1 was non-verbal. Observation on 12/3/25 at 2:30 PM reflected Resident #1 sitting in his chair in the common area. He appeared to be clean and had no odor when passed by him. He was observed alert and moving around a little bit in the chair watching television. Surveyor attempted to speak with him but due to Resident #1 being non-verbal, there was no response. Interview with NP on 12/4/25 at 10:15 AM revealed there would be no adverse reaction if the staff did or did not mention the name of the medication due to Resident #1's cognitive ability. Interview with Medication Aide on 12/4/25 at 01:08 PM revealed she was reeducated on the process of passing medications to residents. She stated she advises residents of their medications when she passes them to the residents. Medication Aide stated if Resident #1 was not advised of the medication he is given nothing can happen. She stated that it is not appropriate not to advise them but some of the residents know their medications they are given. Interview with DON on 12/4/25 at 02:28 PM revealed there would not be any adverse reaction that could have happened if he was not advised of the medication he takes. She stated Resident #1 is mentally incapable of making judgements and his medications are reviewed monthly by the pharmacist. DON stated they have done in-services and watched medication passes as additional education to ensure staff are advising residents of the medications they are being given. Interview with ADM on 12/4/25 at 03:15 PM revealed Resident #1's medication was properly administered by the Medication Aide in the video footage. She stated he is not cognitively capable of understanding whether he was advised the name of the medication or not, but she did advise him she had medication to give to him. ADM stated she doesn't feel it would have changed the effect of anything because he still received his medication and on time. ADM stated measures they have put into place are reeducating the staff, and they are doing checkoffs to advise staff of the proper procedures related to advising the residents what they are doing and what it is for. Review of a facility policy titled Medication Administration and General Guidelines, undated, reflected the following: Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by legally authorized people to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication, monograph of all medications is available in LinkRx otherwise, authorized personnel should refer to Drug Reference material