

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 12/15/2025
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 (Resident #1) residents reviewed for measurable objectives and timeframes. The facility failed to enter dates into the Care Plan when Resident #1 sustained bruises, and no goal or interventions for the resident's diagnosis of schizophrenia (a mental health disorder). This failure could result in inadequate care due to incomplete and inaccurate care plans. The findings include: Record review of Resident #1's face sheet, dated 12/15/25, reflected a -[AGE] year-old male who was admitted to the facility on [DATE] and re-readmitted [DATE]. Resident #1 had diagnoses which included: TBI (traumatic brain injury), ID (intellectual disability, Schizophrenia (a mental health brain disorder), and seizures. The RP was listed as: a family member. Record review of Resident #1's former quarterly MDS, dated [DATE], reflected a BIMS score of Zero, indicative of severe impairment in cognition. The ADLs for: B/B were listed as incontinent of both bowel and bladder. Transfer and Mobility were listed as total dependence. ROM was listed as: impairment lower. The assistive device was a Geri-chair. Mental Illness diagnosis included: schizophrenia and Major Depression. Record review of Resident #1's CP, undated, revealed the resident Resident #1 had a bruise to right lower leg from swinging his leg over the side of a chair; and abdomen bruising due to Lovenox (blood thinner) injection. [The CP did not document when the bruises occurred.] Further record review of Resident #1's CP did not capture any goal or interventions regarding the resident's diagnosis of schizophrenia. [The CP documented the end date for the blood thinner was 10/19/25.] Record review of Resident #1's Skin Assessments revealed: 12/15/25 [date of surveyor 'entrance] reflected: old brown discoloration to RLE (right lower extremity) above outer ankle. 1.0cm x 0.3cm top of right hand due to recent blood drawing. Record review of Resident #1's physician's orders, dated December 2025, reflected the blood thinner, Lovenox, had an end date of 10/19/25. Further review of the physician's orders reflected the resident was given the medication Benzotropine. 1 tablet, 1 MG daily for schizophrenia. Record review of Resident #1's MAR, dated December 2025 reflected no refusals of the Benzotropine medication. During an Observation and interview on 12/15/25 at 4:53 PM Resident #1 was in bed, not alert and not oriented. Resident was cleaned and groomed. Resident struggled to move his body and respond to the surveyor's presence. The resident's disposition was one of involuntary movements. The call light was in reach; the room was cleaned; there were no fall hazards; and the room was homelike. Floor mat and Geri-chair were present, and a camera was present. The bed was at an angle. The Resident could not answer any direct questions due to his cognition. During an interview on 12/15/25 at 4:00 p.m., the Regional RN stated the bruise to Resident #1's right lower leg occurred on 10/03/25 and confirmed the date of the bruise was not listed in the CP. The Regional RN confirmed the CP did not have a specific goal and interventions for the resident's diagnosis of schizophrenia. The Regional RN stated the CP had to be accurate to avoid confusion as to when the resident acquired the bruise and whether interventions were effective. The Regional RN stated the DON [facility had no DON, and the Regional Nurse had assumed the role] or the charge nurse were responsible for the accuracy of the medical record. During an interview on 12/15/25 at 5:10 PM, the ADO stated that clinical records had to be accurate to provide communication for continuity of care. The ADO added that the CP needed to be accurate because it captured the goals and interventions for Resident #1. The ADO stated the interdisciplinary team developed the CP and the DON was responsible for the accuracy of the clinical record and the CP. During an interview on 12/15/25 at 5:26 PM, the Administrator stated the clinical record, and CP had to be accurate to provide continuity of care. The Administrator had no explanation why the CP for Resident #1 did not reflect a goal or interventions for the diagnosis of schizophrenia. Also, the Administrator stated she could not explain why the bruise that occurred in October 2025 was not captured in the CP. The Administrator stated the DON was responsible for the accuracy of the CP and the clinical record. Record review of the facility's Documentation policy undated, read: .The facility will maintain complete and accurate documentation for each resident on all appropriated clinical records sheets.</p>		