

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

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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 06/01/2026
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents could exercise their rights without interference for 1 of 10 residents (Resident #1) reviewed for resident rights. The facility failed to prevent staff from obscuring the view of an authorized electronic monitoring device in Resident #1's bedroom on 05/28/2026. This failure placed residents at risk of abuse, neglect, or maltreatment not being identified. Findings included: Review of the undated face sheet for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included traumatic brain injury, schizophrenia, seizure disorder, and major depressive disorder. Review of the quarterly MDS assessment for Resident #1 dated 05/01/2026 reflected he could not participate in the BIMS assessment due to cognitive impairment. Review of the care plan for Resident #1 dated 09/15/2025 reflected the following: FOCUS Resident/Resident's responsible party has requested electronic monitoring. GOAL Resident/Responsible party will have electronic monitoring in place through review date. INTERVENTIONS-Educate resident/responsible party of their responsibility associated with electronic monitoring including:-Reporting abuse/neglect within 14 days of viewing surveillance or being informed of abuse/neglect by a person(s) viewing video surveillance of what they believe to be abuse or neglect.-Providing a copy of surveillance to facility administration as requested.-Educate resident/responsible party of their responsibility associated with electronic monitoring including:-The need to pay for all costs associated with electronic monitoring (other than cost of electricity); including installation in compliance with life safety and electric codes, maintenance, removal, and repair of equipment.-Make reasonable accommodation for electronic monitoring to be placed by resident/responsible party, including power supply.-Obtain consent from resident's roommate/Responsible party (if applicable) for electronic monitoring-Place conspicuous notice of electronic monitoring at entrance of room. Review of a video dated 05/28/2026 at 6:36 AM reflected two staff members (CNA B and CNA C) entering Resident #1's room and closing the privacy curtain so that it obscured the view of Resident #1, the CNAs, and the bed. What was occurring behind the privacy curtain was not visible, and the noises were not distinguishable. The recording ended with the privacy curtain still closed. During an interview on 05/30/2026 at 5:12 PM, the RP for Resident #1 stated the facility had been instructed many times not to obscure the view of Resident #1 from the camera, even when he was provided incontinent care. She stated she had seen examples of the staff pulling the privacy curtain closed to provide care despite her repeated requests that they not. She stated she did not have older videos to this effect, but she still had one from 05/28/2026. She stated she did not trust the staff to provide adequate care for Resident #1, so she wanted to observe all care to make sure. During an interview on 06/01/2026 at 10:56 AM, CNA B stated she was one of the aides helping Resident #1 in the video from 05/28/2026. She stated they always had to provide help for him with two people present due to a history of allegations by his RP. She stated she closed the privacy curtain for Resident #1 to have privacy. She stated she had not received any instruction about not closing the privacy curtain for Resident #1. She stated she had been employed at the facility for one month. She stated she was aware the privacy curtain blocked the view of the care they provided but (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she thought that was the correct procedure when providing care. A telephone interview was attempted with CNA C on 06/01/2026 at 11:21 PM. A voicemail message was left and not returned as of 06/08/2026. During an interview on 06/01/2026 at 12:32 PM, the SW stated the IDT and the nursing staff had discussed that the staff were not to close the privacy curtain when providing care for Resident #1. She stated the only time they were allowed to pull the curtain was if Resident #1's RP began cursing at staff or saying ugly things to them through the camera. She stated this was a regular occurrence with the RP of Resident #1, and these were the only circumstances in which the staff were permitted to close the curtains while providing care. During an interview on 06/01/2026 at 2:09 PM, the DON stated the staff pulled the curtain to obscure the camera for Resident #1 only when she began cursing at them and/or calling them names. She stated the cursing and name-calling had an effect on the staff, and they could not do their jobs while it was going on. She stated, otherwise, the curtain was to be open with a full view of all care at all times. She stated she had in-serviced about this and spoke about it at staff meetings. She stated she was responsible for ensuring compliance, and she did so by making rounds and observing staff providing care. She stated she did not think there could have been a negative impact on the resident from having the privacy curtain closed. During an interview on 06/01/2026 at 2:58 PM, the ADM stated her understanding was the staff were told not to block the camera during care for Resident #1. She stated it was her responsibility to ensure compliance with the process, and the SW was responsible for implementing all the consents and procedures for authorized electronic monitoring. The ADM stated she monitored for compliance by performing random checks as staff entered surveilled rooms. She stated the possible negative impact on residents of having care obscured from the camera was the RP could not oversee and confirm that proper care was being provided. Review of the facility's policy dated 01/25/2024 and titled Authorized Electronic Monitoring (AEM) reflected the following: Facility and Resident Responsibilities Regarding AEMThe person requesting or using AEM must inform the facility that AEM is being requested or used. Each facility must have the proper documentation and signage in place for the monitoring and must permit a resident or their guardian or legal representative to monitor the resident's room using electronic monitoring devices.		