

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

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Form Approved OMB
No. 0938-0391

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 06/09/2026
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the resident environment remained as free of accidents and hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents hazards and supervision. The facility failed to ensure that Resident #1's bed was in low position, and his alternating air mattress was with the correct settings when Resident #1 experienced an unwitnessed fall on 06/05/2026 at 07:34 PM. This failure could place residents at risk for falls with the possibility of injury, including fractures. Findings included: Review of Resident #1's admission record, dated 06/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and most recently readmitted on [DATE], with diagnoses that included: pressure ulcer of sacral region (an pressure sore to the area just above the buttocks on the lower back), osteomyelitis (an infection in the bone), and end stage renal disease (a chronic condition in which the kidneys lose nearly all of their filtering ability). Review of Resident #1's Quarterly MDS, dated [DATE], reflected a BIMS score was not completed because Yes was selected for Persistent vegetative state/no discernible consciousness. Section M - Skin Conditions reflected Resident #1 had a pressure ulcer/injury and used a pressure reducing device for the bed. Review of Resident #1's care plan, dated 01/30/2026 and last revised on 02/10/2026, reflected a focus of The resident is risk for falls r/t incontinence, Unaware of safety needs with an intervention that included The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; hand rails on walls, personal items within reach). Review of Resident #1's care plan, dated 01/30/2026 and last revised on 04/01/2026, reflected a focus of The resident has a stage 4 pressure ulcer [a pressure ulcer that extends through all layers of the skin and down to the muscle/bone] with an intervention that included The resident requires the use of an air mattress. Review of Resident #1's care plan, dated 01/30/2026 and last revised on 06/06/2026, reflected a focus of The resident has a pressure ulcer with an intervention that included Resident has an alternating air mattress on his bed Review of Resident #1's order summary, dated 06/09/2026, reflected the following orders: May have pressure relieving mattress every shift with a start date of 01/29/2026; May use air mattress d/t pressure ulcer. Check for proper functioning q shift, ensure weight setting is correct, and it is ALT airflow not static. Static is only used during ADL care every shift with a start date of 06/08/2026; May use bolsters [a long, thick pillow or other similar shaped item used to provide support for positioning] to bed every shift for prevent unintentional rolling out of bed with a start date of 06/09/2026; Resident may use air mattress on bed with a start date of 01/29/2026. Record review of Resident #1's progress notes dated 06/05/2026 at 07:34 PM written by the ADON reflected Resident had a fall. Location: Resident Room. Fall information: Unwitnessed, Discovered on floor, Next to bed, Cognition / Behavior at Time of Event: The fall caused a skin tear to below left eye, bridge of nose, Size of the skin tear in cm: 0.1x0.1 nose, 2x .1 cm below eye, New / bleeding, . Nurse standing in doorway of 211. Hear a loud bang noise, entered room [Resident #1's room number] and notice resident was lying on the floor left side of bed facing the door. Notice blood (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676019 If continuation sheet Page 1 of 5

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F 0689 Level of Harm - Actual harm Residents Affected - Few	on the floor and coming from face, resident eyes open, awake. Was able to assess resident and roll him over. Used draw sheet to pick resident up off the floor. Record review Resident #1's hospital discharge instructions, dated [DATE], provided by the facility reflected FINAL DIAGNOSIS, s/p fall ADDITIONAL DIAGNOSIS closed head injury [a head injury that does not break the skull - See CT scan results below] left facial abrasions [an open wound caused by friction] periorbital contusion [bruising around the eye]. Record review of Resident #1's hospital record, dated 06/05/2026, provided by local hospital reflected Resident #1 weighed 77.4 kg (170.28 pounds). A CT scan of the facial bones reflected the following impression (result or finding): Mildly displaced depressed left nasal bone fracture. A CT scan of the brain reflected the following impression: No appreciable acute intracranial abnormality [No injury to the brain]. The nursing assessment reflected Skin: Inspection findings include swelling, to left eye, small laceration to left eye sustained after fall from bed. Record review of facility in-service titled Abuse & Neglect, Q 2 Rounding, Fall Prevention, Fall Risk, Pain Management, Air Mattress Settings, Residents Positioning, dated 06/06/2026, reflected the following: Abuse & Neglect: Q 2 hour rounding: Fall Prevention: Fall Risk: Air Mattress Settings: It is important to ensure every air mattress is set to the resident's correct weight. Proper weight settings allow the mattress to provide the appropriate pressure redistribution, which helps reduce the risk of skin breakdown and pressure injuries. Incorrect settings can also affect the resident's positioning and stability in bed, increasing the risk of falls and discomfort. Nursing staff should verify the resident's weight and check mattress settings regularly, especially after admissions, significant weight changes, or when concerns about skin integrity arise. Resident Positioning and Fall Prevention: When repositioning a resident in bed, it is important to ensure the resident is centered in the middle of the mattress. Proper positioning helps prevent the resident from being too close to the edge of the bed, reducing the risk of falls and injuries. Centering the resident also promotes comfort, maintains proper body alignment, and allows the mattress to provide effective pressure redistribution. Staff should verify the resident's position after every transfer, repositioning, and care activity to ensure safety. Observation on 06/09/2026 at 09:05 AM revealed Resident #1 lying in bed on a low air loss mattress with the bed approximately 8-10 inches off the floor. Resident #1 was observed with swelling to the bridge of his nose and his left eye with surrounding bruising and a linear scab across the bridge of his nose that continued just below the left eye to the outer corner. There were fall mats on the floor on each side of the bed. There was a piece of tape covering the setting on the air mattress pump and a sign that reflected Do not adjust settings taped to the machine. The settings on the pump were set to approximately 170 pounds. During observations performed on 06/09/2026 between 11:30 AM and 1:00 PM, 3 observed air mattresses in the facility with settings set correctly for their corresponding residents. During an interview on 06/09/2026 at 03:10 PM, the ADON stated she was working on 06/05/2026 at 07:34 PM when Resident #1 sustained a fall. She stated she was in the doorway of an adjacent room and heard a loud noise. She stated she locked her cart and went down the hall to find the source of the noise and could see Resident #1 on the floor on the opposite side of the bed from the doorway. She stated she immediately assessed Resident #1 and noticed a laceration across the bridge to his nose, under his left eye, and to the outer corner of his left eye that was bleeding. The ADON stated she got assistance from other staff members to get Resident #1 back into bed and called the practitioner for a tele visit consultation. She stated the practitioner gave orders to send Resident #1 out to the emergency room for evaluation. The ADON stated Resident #1 returned to the facility on [DATE] around 04:00 AM with discharge papers that reflected diagnoses of status post fall, closed head injury, left facial abrasions and periorbital contusion. The ADON stated she was not aware of any fractures that occurred as a result of the fall. She stated the bed was about waist height off the floor, so it was higher than was needed to keep his Foley catheter off the floor, and the air mattress settings were set for a resident who weighed 220 pounds and Resident #1 weighed about 170 pounds. She stated the footing of the machine next to his bed appeared to have caused the injury with bleeding. The ADON stated CNA A was in Resident #1's room approximately one hour prior to the (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fall to provide care and repositioning. She stated Resident #1 had not had any decline in condition or change in demeanor since the fall. During an interview on 06/09/2026 at 04:12 PM, CNA A stated she had worked with Resident #1 on 06/05/2026 and had provided care and repositioned him around 06:30 PM. She stated she left Resident #1 positioned on his left side in the middle of the bed with the wedge pillow behind his back and pillows under and between his knees. She stated she left the bed about a foot off the ground, but she did not look at or touch the air mattress pump while in Resident #1's room. CNA A stated she knew Resident #1 was on an air mattress and they were set to the resident's weight, but she didn't know anything else about the air mattresses. She stated she clocked out for break and was notified during her break that Resident #1 had a fall. During an interview on 06/09/2026 at 04:39 PM, the DON stated Resident #1 had a fall on 06/05/2026. She stated she had discovered that the ADON was near the room, but no staff were in the room when Resident #1 fell from bed. She stated the ADON heard a noise and after looking for the source of the noise she found Resident #1 on the floor next to his bed. The DON stated she thought the cause of the fall was the alternating air loss mattress. She stated the mattress worked by the air inflating and deflating in cycles on each side of the bed. The DON stated that it could be possible for the mattress to flip someone out of bed. The DON stated the ADON told her the bed was about 2 feet off the ground when Resident #1 fell out of bed. She stated the fall precautions in place for Resident #1 were to keep the bed in low position, but the facility had to be careful about how low to put the bed due to all of the machines that Resident #1 required. The DON stated the injuries Resident #1 received during the fall were a swollen eye and a cut across the bridge of his nose that went over to the outer corner of his eye. She stated the discharge instructions and report received from the emergency room did not indicate any fracture had occurred. The DON stated the Administrator was on leave. Review of, undated, facility policy titled Fall Policy reflected Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family. A Fall Risk Assessment will be completed on admission and after each fall. The MDS 3.0 will also assist in determining a resident who is a fall risk. Appendix A Fall Intervention Methods Environmental. Bed height needs to be appropriate height with wheels locked.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of three residents (Resident #1) reviewed for catheter care. The facility failed to ensure Resident #1's urinary drainage bag was found hanging from the bed frame with the bottom of the bag touching the floor/floor mat on two occasions on 06/09/2026. This failure could place residents with indwelling catheters (a tube that is inserted through the urethra to the bladder to drain urine) at risk of developing infections. Findings included: Review of Resident #1's admission record, dated 06/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and most recently readmitted on [DATE], with diagnoses that included: pressure ulcer of sacral region (an pressure sore to the area just above the buttocks on the lower back), osteomyelitis (an infection in the bone), and end stage renal disease (a chronic condition in which the kidneys lose nearly all of their filtering ability). Review of Resident #1's Quarterly MDS, dated [DATE], reflected a BIMS score was not completed because Yes was selected for Persistent vegetative state/no discernible consciousness. Section H - Bladder and Bowel reflected Resident #1 had an Indwelling catheter. Review of Resident #1's care plan, dated 01/30/2026 and last revised 02/10/2026, reflected a focus of The resident has Indwelling Catheter: 18FR/10cc with an intervention that included Check tubing for kinks and maintain the drainage bag off the floor. Review of Resident #1's order summary, dated 06/09/2026, reflected the following orders: Empty foley drainage bag every shift with a start date of 02/26/2026; Foley Catheter: 18_F with _10_bulb - change for occlusion, leaking, closed system was compromised one time a day every 30 day(s) with a start date of 01/29/2026; Monitor F/C q shift for leakage, blockage, sediment buildup, or low output every shift with a start date of 01/29/2026. Observation on 06/09/2026 at 09:05 AM revealed Resident #1 lying in bed on a low air loss mattress with the bed approximately 8-10 inches off the floor. Resident #1's urinary drainage bag was hanging from the bed frame on the right side near the foot of the bed and the bottom of the bag was touching the floor. Observation on 06/09/2026 at 12:31 PM revealed Resident #1 lying in bed on a low air loss mattress with approximately 8-10 inches off the floor. Resident #1's urinary drainage bag was hanging from the bed frame on the right side near the foot of the bed and the bottom of the bag was resting on the fall mat next to the bed. During an interview on 06/09/2026 at 03:10 PM, the ADON stated she had been trained in the care of an indwelling catheters. She stated she was trained that the urinary drainage bag is to hang from the frame of the bed but not be allowed to touch the floor. The ADON stated if the urinary drainage bag were allowed to touch the floor, then it could cause contamination and possible infection in the resident. She stated the charge nurses were responsible for monitoring to ensure the urinary drainage bags were hung on the bed frame but were not touching the floor during their rounds. During a phone interview on 06/09/2026 at 03:53 PM, CNA B stated she had been trained to provide care to indwelling catheters, and it was important to ensure that the urinary drainage bag did not touch the ground because it could contaminate the bag and cause infection in the resident. She stated all staff were responsible for monitoring the placement of urinary drainage bags during their rounds. CNA B stated she was responsible for providing care to Resident #1 on the morning of 06/09/2026. She stated Resident #1's urinary drainage bag kept falling on the ground that morning and she had checked it several times that day. During an interview on 06/09/2026 at 04:04 PM, RN C stated she had been trained to keep the urinary drainage bag hung so that it did not touch the floor because the bacteria on the floor could cause an infection in the resident. She stated she was the nurse in charge of Resident #1 on 06/09/2026 and did not see his urinary drainage bag touching the floor. RN C stated it was the responsibility of all staff to monitor for the correct placement of urinary drainage bag during their rounds. During an interview on 06/09/2026 at 04:12 PM, CNA A stated she had been (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trained to provide care for indwelling catheters. She stated she was trained to ensure the urinary drainage bag was to be hung where it did not touch the floor because touching the floor could contaminate the bag and cause an infection in the resident. She stated it was the responsibility of all direct care staff to monitor the urinary drainage bag was hung properly when they did their rounds. During an interview on 06/09/2026 at 04:39 PM, the DON stated she expected direct care staff to ensure that urinary drainage bag did not touch the ground or floor mat. She stated if the bag touched the ground or floor mat then the resident could potentially develop an infection. She stated management was responsible for monitoring to ensure proper placement of urinary drainage bag during their rounds. She stated the CNAs are educated to know the expectation of where to hand the urinary drainage bag. The DON stated the Administrator was on leave during the investigation. Review of, undated, facility policy titled Catheter Care reflected General Guidelines.10. Be sure the catheter tubing and drainage bag are kept off the floor.		