

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 07/15/2026
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.			
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and resident's representative(s) of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 (Resident #1) of 5 residents reviewed for discharge planning. The facility failed to notify Resident #1's RP of Resident #1's discharge, reasons for the move, and right to appeal in writing, in a language and manner they understand, as soon as practicable before the discharging Resident #1 on 04/23/2026 to another facility. The facility failed to send a copy of the notice of Resident #1's discharge to the facility's Ombudsman as soon as practicable before discharging Resident #1 on 04/23/2026 to another facility. This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. Findings included: Record review of Resident #1's face sheet, dated 07/15/2026, revealed a fifty-four-year-old female who was admitted to the facility on [DATE] with a diagnosis that included brief psychotic disorder (a short-term mental health condition defined by the sudden onset of psychotic symptoms-such as delusions, hallucinations, disorganized speech, or catatonic behavior), schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia symptoms (like delusions or hallucinations) and mood disorder symptoms (like depression or mania)), bipolar disorder, current episode manic severe with psychotic secondary features (a mental health condition with major mood shifts, currently experiencing high-energy mania marked by racing thoughts, reduced sleep, and impulsive actions. The manic state causes major disruption in daily life, work, or safety, often requiring hospital care. A break from reality involving hallucinations or delusions (such as false beliefs of grand power or importance)). Record review of Resident #1's care plan revealed care plan cancelled dated 04/27/2026 had a focus of Resident #1 was at risk for elopement as evidenced by exit seeking and voiced wanting to leave dated 04/16/2026 with intervention dated 04/18/2026 placed 1:1 for 48 hours. Resident #1's care plan did not include discharge planning. Record review of Resident #1's MDS Resident Assessment and Care Screening dated 04/22/2026 Section C - Cognitive Patterns reflected a BIMS score of 0 indicating severe cognitive impairment, section E0900. Wandering - Presence and Frequency - Behavior of this type occurred 4 to 6 days, but less than daily, and E1000. Wandering - Impact the wandering placed the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility). Record review of Resident #1's progress notes dated 04/18/2026 reflected Resident #1 walked around front lobby. Staff was watching resident closely due to her recent outburst about wanting to leave this hospital. When visitor went to punch in door code, resident approached him. Staff let visitor know that resident could not go outside without a staff member. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 agreed to come to common area to listen to piano music that volunteer is playing. Let the ADON know of behavior. Interventions: Encourage activities, Music or sensory stimulation, Review of Resident #1's progress note dated 04/18/2026 reflected Resident #1 wandered down hallway. Resident stated she did not know where she was or how she got here. Resident #1 entered her room and then left and wandered down hallway. Resident #1 was redirected by staff. Review of Resident #1's progress note dated 04/19/2026 reflected Resident #1 was up wandering in hallway. Resident #1 noted trying to enter other residents' rooms. Resident #1 redirected back to her room. Staff encouraged Resident #1 to lie down and get some rest. Resident #1 would lie down for several minutes at a time and then get back up and go to nurses' station or wander down hallway. Staff had to redirect Resident #1 multiple times. Review of Resident #1's progress note dated 04/19/2026 reflected staff heard door alarm sound and followed the sound. A resident informed staff that a lady was outside. Nurse sent a CNA to the hallway where the alarm sounded while nurse when to the front of the building and walked outside. Nurse entered building through hall 4 and saw CNA walking with Resident #1 on hall 4. Staff asked Resident #1 what she was doing. Resident #1 said she held the door for 15 seconds. Resident #1 was placed on 1:1 (means a dedicated staff member is assigned continuously to watch and assist a single resident). Review of Resident #1's progress note dated 04/19/2026 reflected staff spoke with Resident #1's RP about Resident #1 exiting out the door and coming back in and someone sitting with Resident #1 1:1. Review of Resident #1's progress note dated 04/19/2026 reflected elopement/Attempt interventions: 1:1 monitoring, Review of Resident #1's progress note dated 04/19/2026 reflected Resident #1's RP informed that the SW was seeking a secure unit for Resident #1 because she was exit seeking. Review of Resident #1's progress note dated 04/22/2026 reflected elopement/attempt follow-upcurrently increased wandering, Resident #1 continued to wander around entire facility. Interventions: 1:1 monitoring. Review of Resident #1's progress note dated 04/22/2026 reflected Resident #1's RP was notified that Resident #1 had been accepted into another SNF with a secure unit. The RP requested that Resident #1 be discharged to a SNF closer to [another city]. The Social worker called several SNFs to see if they had a secure unit and only 2 had a secure unit but they had not responded. Clinicals were sent to other SNFs. Review of Resident #1's progress note dated 04/23/2026 reflected elopement note - follow-upCurrently exit seeking, no further elopement attempt, resident still 1:1. Record review of Resident #1's Discharge Summary by LVN A reflected on 04/23/2026 Resident #1 was transferred to another SNF with a secure unit. Discharge summary reflected no physician signature. During an interview on 07/15/2026 at 11:17 AM with the RNC she said it was the responsibility of the team together to discharge residents, both the nursing team and the SW. The RNC said she did not see any information in Resident #1's EMR that Resident #1's RP received written communication about Resident #1's discharge or that the Ombudsman was notified. The RNC said because the DON was out of the building it was the responsibility of the Administrator to make sure the discharge went smoothly. The RNC said the facility should have followed their policy when Resident #1 was discharged . The RNC said a possible negative effect of not following a discharge policy was that the RP might not have known where the Resident went. During an interview on 07/15/2026 at 1:16 PM with Resident #1's RP she said she did not want Resident #1 moved out of the facility and into the facility she was transferred to. Resident #1's RP said she was not okay with moving Resident #1 to the facility she is currently living in and she fought with the facility about moving Resident #1. The RP said the facility told her Resident #1 had to go to the place Resident #1 was sent. Resident #1's RP said she asked about other SNF locations. Resident #1's RP said the facility insisted Resident #1 go to the facility she was sent to. Resident #1's RP said Resident #1 had just gotten to the facility and Resident #1 (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident who is being discharged should receive a notice of their right to appeal the discharge. During an interview by telephone on 07/15/2026 at 3:45 PM with the DRO she said even in urgent situations a written notice of a copy of the discharge documentation giving the specific reason the facility gave for the immediate discharge must be sent to the resident or the resident's RP and to the Ombudsman before or immediately upon the emergency move. The DRO said these requirements are for the residents' protection at discharge. She said a negative impact of not providing the information for the resident or the resident's RP right to appeal would be a possible uprooting of a resident and the loss of the primary support and the psychological confusion to the resident being moved to a different environment. On 07/15/2026 at 4:06 PM an attempt to call the former facility Administrator leaving a voice mail and a text message. No response to messages received. Record review of facility Discharge or Transfer Facility Initiated discharge date d 02/12/20-25 reflected the facility will permit each resident to remain in the facility and not transfer or discharge the resident from the facility. In the following limited circumstances, this facility may initiate transfers or discharges: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; To demonstrate that any of the circumstances are permissible for a facility to initiate a transfer or discharge as specified in A, the medical record will show documentation of the basis for transfer or discharge. This documentation must be made before, or as close as possible to the actual time of transfer or discharge. For circumstances A for permissible facility-initiated transfer or discharge, the resident's physician must document information about the basis for the transfer or discharge. Additionally, for circumstance A above, the inability to meet the resident's needs, the documentation made by the resident's physician must include: The specific resident needs the facility could not meet; The facility efforts to meet those needs; and The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility. Long-Term Care Regulation Provider Letter Nursing Facility Resident Discharge and Appeal dated 09/29/2022 reflected the purpose of this letter is to provide guidance to Nursing Facilities regarding resident discharges and discharge appeal hearings. Providing clear notice and documentation during a discharge are legal requirements and essential to protecting the rights and dignity of residents. Reasons for Discharge Permitted by Rule A - Nursing Facility must determine its capacity and ability to care for a resident upon admission. The facility must allow a resident to remain in the facility and may not involuntarily discharge the resident unless the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility. Proper Discharge Notification if a Nursing Facility initiates a resident discharge, the facility must provide written notification of the discharge-in a language and manner the resident can understand-to the resident, the resident representative (if applicable), and a representative of the Long-Term Care Ombudsman Program, at least 30 days before the intended discharge date. The discharge notification must include: the reason for the discharge; the effective date of the discharge; the location to which the resident is being discharged; a statement that informs the resident of his or her rights to appeal the discharge by requesting a hearing through the Health and Human Services Commission (HHSC) within 90 days; information on how to obtain an appeal form and assistance in completing and submitting it; contact information of the managing local ombudsman and the toll free number for the Long-Term Care Ombudsman Program, which is [PHONE NUMBER]; if applicable, for residents with a mental illness, contact information of the state mental health authority; and if applicable, for residents with an intellectual or developmental disability (IDD), contact information for the authority for individuals with IDD, along with the contact information for the agency responsible for the protection and advocacy of individuals with IDD. 3 A Nursing Facility must provide a discharge notice as soon as (continued on next page)		

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