

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

Printed: 11/21/2025
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 02/12/2025
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.			
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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. Based on interviews, observations, and record reviews, the facility failed to provide a notice of residents' rights to the residents during the residents' stay for three out of four halls. Information of residents' rights was posted only on Hallway 4 and not accessible for viewing by all facility residents. Resident rights were not included in residents' admission packets since November 2023. These failures placed residents at risk of a decreased quality of life, decreased awareness or their rights, and decreased execution of their resident rights. The findings were: Record review of facility's admission packet dated 10/19/22 reflected Health Care Center Policies, Information, and Required Notices: Acknowledgement of Receipt of Policies, Information, & Required Notices - Statement of Resident Rights Notice of rights and services (19.403)(B)(6). The Health Care Center must inform the resident, the resident's next of kin or guardian, both orally and in writing, a language that the resident understands. Of his rights and all rules and regulations governing resident conduct and responsibilities during the resident's stay in the Health Care Center. This notification must be made prior to or upon admission and during the resident's stay. The Health Care Center must post a copy of DADS' rules and Health Care Center's policy in a conspicuous location. A confidential group interview on 02/11/25 at 2:00 PM with 21 residents revealed that they were unfamiliar with how to find out about rights. When asked if they knew about their resident rights and if the staff talked about and reviewed the rights of residents, they said, no. No resident was aware of what their rights were, where to locate them in the facility, and said a copy of resident rights had not been either given to or discussed with them. Review of Resident #23's BIMS, dated 1/3/25 revealed a score of 15, indicating intact cognition. Review of Resident #66 BIMS, dated 1/28/25, revealed a score of 12, indicating moderate cognitive impairment. (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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #45 BIMS, dated 12/31/24, revealed a score of 12, indicating moderate cognitive impairment. Observations on 2/12/25 at 1:14 PM revealed signage of Residents' Rights located directly inside the right and left sides of hallway 4. A tour of the facility revealed no other observations of resident rights postings. Interview on 2/12/25 at 10:51 am with Resident #23, whose room was on the 400 hallways, revealed no one had talked to him about his resident rights and he was not given a document listing resident rights. He felt like communicating to him about his resident rights was something he would like. He said that he did not have any complaints with the facility, but if he knew his resident rights, he would be more informed about living at the facility. He said he had not noticed that there were signs at the end of the hallways that listed resident rights, ombudsman information, or where to call if he had a complaint. Interview on 2/12/25 at 10:56 am with Resident #66, whose room was on the 200 hallways, revealed he was not told his resident rights or given a document that listed his resident rights. He said it was important and good to know their rights. He said he would like the facility staff to tell him his rights or give them to him on paper. He said he had not seen any postings in the facility about resident rights, the ombudsman, or where to call if he had a complaint. Interview on 02/12/25 at 10:19 am with Resident #45, who's room was on the 200 hallways, revealed no one had told her about her rights while she had been at the facility and that was incomplete information, but she had not had an occasion to worry about her rights. She said knowing her rights would be helpful because it would be a guideline to know what she could do and could not do as a resident and what the facility could and could not do. She said she felt knowing her rights was extremely important to her. She said she had not seen any posting at the facility of resident rights, ombudsman information, or who to call if she had a complaint. Interview on 2/12/25 at 11:46 am with the M/AC revealed she was responsible for providing and obtaining signatures on all resident paperwork including the resident admission packet. She said she had been working at the facility since 11/15/23. She revealed she did not know that the resident rights document, referenced in the admission packet as an attachment, needed to be included in the resident admission packet. She said she had never included the residents' rights document with the facility admission documents when an admission packet was given to the resident or their RP to review and sign. She did not audit the packets for accuracy. She revealed she thought it was important that the residents were provided their rights in a manner that each resident could understand, and it was abuse if they were not informed of their rights. She said she did not know that residents had not received the residents' rights. Observation on 2/12/25 at 1:14 PM during a tour of the facility with the Administrator revealed that the only resident rights postings where on the 400 hallway. Interview on 2/12/25 at 1:14 PM with the Administrator revealed that he did not think that the resident rights postings, which were only posted on the 400 hallway, were accessible to all residents and that they should be posted on all hallways for residents to have access to view. He said the negative impact of them not being accessible to all resident was that all residents did not have access to the information about their facility rights. (continued on next page)		

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 2/12/25 at 11:38 am with the Administrator, who had been at the facility beginning 1/14/25, revealed he was the supervisor for the M/A C and it was his expectation that residents received all attachments, including resident rights, when they received their admission packet and he did not open up the packets to confirm that residents were receiving the required information. His expectation was for there to be follow through with the admission packet to confirm that the residents received all the required information. He checked the admission packet but did not open the packet to observe if the packet contained all the documents residents were supposed to receive. He said the M/A C had no clue the residents were not receiving the required information. He said the negative impact of the resident not being informed about their rights was that they would not know what they could expect or not expect and if they had an issue, they would not know what to do and how to remedy the issue.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service in 1(DA B) of- 8 1 kitchen staff in that: DA B had not received training from facility management staff, mandatory online training, or obtained a food handlers certificate before working in the kitchen. This could leave the resident's at risk of consuming improperly handled food and a contracting a foodborne illness Findings included: Record Review on 02/12/25 at 2:30 PM of DA B's employee file revealed her application and background check, but nothing else. In an interview with DA B on 02/10/25 at 9:30 am, she stated that she had not been trained on how to use the dishwasher,. She stated she was not sure what temperature was appropriate for the dishwasher and what level the disinfectant was supposed to be at. In an interview with DA A on 02/10/25 at 9:35 am, she stated that DA B was hired on 02/04/25 and that she was trying to help her out, but was not able to teach her everything. She stated that a traveling dietary manager would show up to order food occasionally, but the kitchen staff was handling all the daily operations and cleaning. In an interview with DA B on 02/10/25 at 2:09 PM, she stated that she was hired on 02/04/25, and the only person that coached her was DA A. DA A She stated DA A had told me her about the dishwashers and how to do the resident orders. DA A showed her the difference between the mechanical and regular diet. The lady in HR had told DA B to do the online trainings, but she was gone all last week. DA B had not received her food handler's certification yet. She knew she was supposed to label and date foods , but did not get trained, and did not know how long food was good for. DA B She had only unloaded a delivery truck once and was unsure how to do it properly. She stated she was worried that she was making mistakes while serving the resident's food because she didn't know what she was doing. In an interview with TDM on 02/11/25 at 2:00 PM, she stated that her first day in the kitchen was 02/10/25, and she not aware that DA B had not received a food handlers certificated, finished her online trainings, or had not had any oversight by a dietary manager while she worked. She stated that when employees are hired, they should go through their online trainings and get their food handlers certificate before working in the kitchen. After the online training, employees should receive an orientation to the kitchen and then shadow another dietary aide. After, they should work under the supervision of a dietary manager and dietary aide until they completed their competency checks by the dietary manager. She expected the administrator to manage the kitchen with the help of other dietary managers from nearby facilities. She stated that there was another dietary manager from a nearby facility that had come to help out, but she was unaware when the manager came to oversee. She stated the residents could get the wrong food and choke or get sick if employees did not have proper training. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 02/11/25 at 11:30 AM, he stated that he thought the traveling dietary managers were training the employees when they came in to assist the kitchen. He stated that he did not know why she had not completed her online trainings and that he knew she should have a food handlers' certificate before working in the kitchen. In an interview with HR on 02/12/25 at 12:30 PM, she stated that she hired DA B on 02/04/25 and then had left for a family emergency the next day. HR did not coordinate any further training for DA B after her hire. She stated that she should have completed her online trainings and received a food handlers' certificate before working in the kitchen. She stated she knew employees should be working with other employees and dietary managers before working on their own in the kitchen. She stated if employees did not have training, they could get the resident's sick by not serving food properly. In an interview with the CRD on 02/12/25 at 11:45 am, she stated that she was unaware DA B had not had her training. She was aware that there was no full-time dietary manager, but the administrator should have communicated with regional management about having an untrained employee. The employees should complete their online training and get a food handler certificate before working in the kitchen. She stated there is was no reason why DA B should not have had the proper training because the traveling dietary manager should have been training her while she was there. The employees should be watched by other dietary aides and then checked off on the competency lists. She stated that there was likely no actual risk to residents because she was unaware what trainings had not been completed for the employees, and she could not speak to the previous knowledge of the employee. Record Review of DA B's employee file revealed her application and background check, but nothing else. No facility policies were provided on training new dietary employees.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation. 1. The facility failed to properly label food and dispose of store perishable foods in the dry storage pantry and walk in fridge. 2. The facility failed to ensure the ice machine was properly cleaned. These failures could place residents who were served from the kitchen at risk for consuming hazardous expired food and developing foodborne illnesses. Findings Included: Observation on 02/10/25 at 9:30 am revealed a 50-pound bag of yellow onions sitting in water on the floor in the dry storage room. Observation on 02/10/25 at 9:38 am revealed cold eggs sitting on the stove top in a pan with a spatula in the pan. Observation on 02/10/25 at 9:39 am revealed a pitcher of tea and a pan of cake sitting in the food warmer. The warmer was in the off position. Observation on 02/10/25 at 10:32 am revealed the inside of the ice machine had an unknown black slime by the internal dispenser. Observation on 02/10/25 at 10:36 in the dry storage room revealed undated red onions in a container that had sprouting greens from the tops. Observation on 02/10/25 at 10:36 revealed the 50-pound bag of onions leaking water from the bottom of the bag . Observation on 02/10/25 at 10:37 am revealed a large can in the dry storage without a label or date . Observation on 02/10/25 at 10:43 am revealed a box labeled simply potatoes with the expiration date of 01/30/25. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/10/25 at 9:40 am, [NAME] A stated that the onions were not sitting in water, and she didn't know why they were leaking. She stated that the warmer had been working shortly before and she did not know why it was off. She stated the cake and tea were only put in there a short time, but should have been refrigerated. She said the eggs on the stove were from breakfast and she had not had the time to throw them out. She stated she did not throw out or remove cans without a label or date; she would just not use the cans. She stated the red onions needed to be thrown out. She stated that all food should be thrown out by the expiration date and opened food can be 7 days in the fridge. She stated she had been trained 18 years ago by the dietary manager when she started working at the facility. She stated if they didn't take care of the food properly, the residents could get sick. During an interview on 02/11/25 at 2:00 PM with the TDM , she stated that her first day in the this kitchen was the day before. She did not know how long they had been without an acting dietary manager. She stated all foods exposed to water, improperly labeled or dated, or questionable should be thrown out. She expected the employees to follow all facility policies, Texas Food Code , and to ask, if they didn't have training or were unsure. She stated the ice machine should have been cleaned by the previous dietary manager 1 time a month. During an interview with DA A 02/11/25 02:28 PM, she stated that the tea and the cake should have been placed in the refrigerator. She stated All foods needed to be labeled and dated. If not, they should have been thrown out. She stated that the ice machine was supposed to be cleaned by the previous dietary manager and she did not know when it had last been cleaned. She stated the residents could become sick from the food especially if it's was expired. In an interview with CRD on 02/12/25 at 11:45 am, she stated that she has not been onsite in the facility since the end of 2024. She stated that she expected the employees to follow the Texas food code and facility policies and procedures . Record review of the facility's policy entitled Cleaning of the Ice Machine stated: 4. If any soil or food stains are present wash with all-purpose cleaner and rinse well. 5. Wipe down all food/ice contact surface with a sanitizer solution, per manufacturer instructions. DO not rinse. Record review of the facility's policy entitled Food Storage and Supplies stated: Food items that are opened need to be used within 7 days of opening date. If in doubt, the dietary manager should inspect and determine if they are best quality for use.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for two of two medication aides (MA A and MA B) observed for infection control practices during medication pass. A) MA A failed to sanitize the blood pressure cuff during medication pass after using it on Resident #46 then using it on Resident #45. B) MA B failed to sanitize the blood pressure cuff during medication pass after using it on Resident #133 then using it on Resident #28. This failure could place residents who require assistance with medication administration at risk for healthcare associated cross-contamination and infections. Findings included: A) Review of Resident #46's face sheet dated 02/11/2025 reflected she was admitted on [DATE] and readmitted on [DATE] with the following diagnoses anemia (Deficiency of healthy red blood cells in blood. Red blood cells are essential to carry oxygen to all parts of the body.), chronic viral hepatitis C (viral infection that causes liver swelling, called inflammation) and hypertension (High pressure in the arteries. Symptoms varies from person to person and generally include unexplained fatigue and headache.). Review of Resident #46's quarterly MDS assessment dated [DATE] reflected she was assessed to have a BIMS score of 15 indicating she was cognitively intact. Review of Resident #45's face sheet dated 02/11/2025 reflected she was admitted on [DATE] with the following diagnoses hypertension, congestive heart failure (long-term condition in which your heart can't pump blood well enough to meet your body's needs.), and atrial fibrillation (A disease of the heart characterized by irregular and often faster heartbeat.). Review of Resident #45's annual MDS dated [DATE] reflected she was assessed to have a BIMS score of 12 indicating she had moderate cognitive impairment. Observation on 02/11/2025 at 7:37 AM revealed, MA A took the blood pressure monitor from the top of the med cart and without sanitizing it, she took the blood pressure of Resident #46. After completing the blood pressure measurement for Resident #46, without cleaning the blood pressure monitor, she kept it on the top of the medication cart and moved to next resident. MA A then took Resident #45's blood pressure with the same blood pressure monitor without cleaning the monitor. In an interview on 01/22/2025 at 8:00 AM, MA A stated she was trained to clean the blood pressure monitor between residents and stated she should have cleaned the blood pressure monitor using the sanitizing wipes to prevent the spread of germs. MA A then took a sanitizing wipe from her medication cart and cleaned the blood pressure monitor. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B) Review of Resident #133's face sheet reflected she was admitted on [DATE] with the following diagnoses of hypertension and hyperlipidemia (is an excess of lipids or fats in your blood. This can increase your risk of heart attack and stroke because blood can't flow through your arteries easily.) . Review of Resident #133's initial MDS assessment dated [DATE] reflected the MDS was in process of completion the BIMS was not yet completed. Review of Resident #28's face sheet dated 02/11/2025 reflected she was admitted on [DATE] with the following diagnoses dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) and. Review of Resident #28's quarterly MDS assessment dated [DATE] reflected she was assessed to have a BIMS score of 15 indicating she was cognitively intact. Observation on 02/11/2025 at 08:19 AM revealed, MA B took the blood pressure monitor from the top of the med cart, and without sanitizing it, she took the blood pressure of Resident #133. After completing the blood pressure measurement for Resident #133, without cleaning the blood pressure monitor, she kept it on the top of the medication cart and moved to next resident. MA A then took Resident #28's blood pressure with the same blood pressure monitor without cleaning the monitor. In an interview on 02/11/2025 at 8:20 AM, MA B stated she should have cleaned the blood pressure monitor between residents to prevent the spread of infection. She stated she just forgot she was concentrating on the medication pass. In an interview on 02/12/2025 at 1:35 PM, the DON stated it was her expectation that blood pressure cuffs be cleaned between residents to ensure no cross contamination occurs to prevent infections. Review of the facility's policy entitled fundamentals of infection control precautions dated 2019 reflected A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions .Non-invasive resident care equipment is cleaned daily or as need between use by the nursing assistant. Equipment that is visibly soiled with blood or body fluids will be cleaned immediately with an approved disinfectant by the nursing assistant. A documentation system will be maintained of the cleaning .		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical and electrical equipment in safe operating condition in 1 of 1 kitchen, in that: The coffee brewing system was not heating. The left side of the double oven was not heating. One well on the steam table was not heating The mobile heated delivery cart was not maintaining a proper temperature. This deficient practice could place residents at risk of decreased resident's quality of life who receive meals from the kitchen and could result in foodborne illness for residents who received meals from the kitchen. Findings included: Observation in the kitchen on 02/10/2025 at 9:15 am revealed the heated delivery cart on with the temperature reading 75 degrees . Observation in the kitchen on 02/10/2025 at 9:15 am revealed the coffee pot had an error message stating, heating element malfunction. Observation in the kitchen on 02/10/2025 at 11:30 am revealed the left well of the steam table was not working. Observation in the kitchen on 02/10/2025 at 11:30 am revealed the left side compartment of the oven was not hot while the right side compartment of the oven was. During an interview on 02/10/25 at 9:40 am [NAME] A stated that the warmer had only been working intermittently for a few months. [NAME] A stated that it should have reached 120 degrees while on. She said that it would work sometimes, after they had to reset the plug, but it was not consistently working. The maintenance department had been notified verbally by her previous dietary manager. She stated that they had not had a working coffee pot for over a week. She was unsure if anyone had called the company responsible for servicing the coffee pot. She believed it was the dietary manager's responsibility to call maintenance or company about broken equipment. She stated she would tell them again after her shift ended. During an interview on 02/10/25 at 11:50 am, DA A stated that she had spoken to the administrator and the maintenance department about the broken equipment last week. She stated the oven had been broken since November, but the maintenance person had inspected the equipment, but never returned about it. The warmer only worked intermittently and she was sure they had called the company to repair the coffee pot. She stated the steam table well has not been working for a few months. She could not recall when it went stopped working. (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with TDM on 02/11/25 at 2:00 PM, she stated her first day in the kitchen was the previous day, 02/11/25. She said that she noted the equipment was broken and had talked to the administrator. The administrator was working with the necessary companies to fix the equipment. During an interview with MS on 02/11/25 at 1:35 PM, he stated that he was made aware that of the oven and, steam table were broken from the previous dietary manager over two months ago. He stated the warmer had only worked intermittently. The coffee pot had been repaired earlier in the day . He stated that the protocol was to receive maintenance orders either verbally or through the QR code. He would assess the repair and then call the area supervisor if he could not replace it. He still had the maintenance requests for the broken equipment, but was waiting for an outside company to come fix the steam table and oven . He stated he was unaware that warmer issue was due to the equipment malfunctioning. Previously, he believed it was an electrical issue because the outlet couldn't handle the amount of equipment plugged into it. He had instructed the kitchen on how to prevent the plug from shutting off. In an interview with AMS on 02/11/25 at 2:35 PM, he stated that he knew the oven and the steam table were broken. He was unaware of the coffee pot, but expected an outside company to repair that. He stated he expected the MS to fix the steam table because it was a basic repair. He stated that he was made aware around two months again that part of the oven wasn't working, but had not heard anything else about the situation. He said that repairs should be logged in their system and assessed by the maintenance supervisors. He stated If the repair could not be done onsite, he expected to be notified. He expected to be notified of repairs that were needed by a piece of equipment that was not under a contract, like the coffee pot company. He said he did not look at the pending maintenance requests of the facilities until he received a complaint. He had not received any complaints about the facility's maintenance and thought they were ok. He stated he should have been contacted and would have helped fix the problems. In an interview with, CRD, on 02/12/25 at 11:45 am, she stated that she knew the equipment was broken, but was not aware that the previous dietary manager did not follow up on the broken equipment. She stated that if she knew the equipment was broken, she would have stepped in to make sure it got fixed. She stated there was a missing invoice about the oven that was resolved. In an interview with the Administrator on 02/10/25 at 11:35 am, he stated that he was made aware of the kitchen equipment being broken two days ago. He was aware of the coffee pot and was awaiting a representative from the coffee equipment company. He stated that he expected his maintenance director to take care of the problem and update him on the status of the equipment. He said that there was a missing invoice that went unpaid, so the company did not come out to fix the oven since he started in January of 2025 . He felt it was unnecessary to have the equipment in nonworking condition and that the resident's quality of food would suffer because of it. Record review of maintenance logs reveled the coffee pot maintenance had been called in on 02/10/25. No other records were available for other broken equipment. No facility policies were available for equipment maintenance were provided before exit.		