STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675356	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Bastr	400 Old Austin Hwy Bastrop, TX 78602

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one of six residents (Resident # 5) reviewed for care plans. The facility failed to develop a comprehensive care plan to reflect Resident #5 needed in room activities. These failures could place residents at risk of not receiving appropriate interventions to meet their psychosocial needs. Findings include: 1. Record review of Resident #5's face sheet, dated 06/30/2026, reflected an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included cognitive communication deficit (an impairment in communication skills caused by disrupted thinking and mental processes- such as attention and memory rather than a primary speech issue), panic disorder (intense rush of physical and mental fear even when there is no actual danger or obvious trigger present), and age-related cognitive decline (the gradual, natural slowing of the brain processing and memory recall that occurs as people grow older. It may take slightly longer to learn new skills or multitask). Record review of Resident #5's admission MDS Assessment, dated 05/13/2026, reflected Resident #5 had a BIMS score of 15, which indicated her cognition was intact. Resident #5's activity preferences that were very important to her were the following:Having books, newspapers, and magazines to readBe around animals such as pets.Keep up with the newsGo outside to get fresh air when the weather was good. Record review of Resident #5's Comprehensive Care Plan, dated 5/25/2026 and revised on 06/02/2026 reflected Resident #5's activity care plan was not revised to meet her current activity preferences (receive in room activities).Record review of the list of residents on the in-room activity program, not dated, reflected Resident #5 was to receive in-room activities. During an observation and interview on 06/30/2026 at 1:00 p.m., revealed Resident #5 was lying in her bed. She was watching a talk show on television. Resident #5 stated she currently did not prefer to be in a group with other people. She stated she becomes nervous (feeling worried or slightly afraid, often accompanied by physical tension in the body) sometimes when she was around other people. Resident #5 stated she preferred for someone to come to her room and do activities instead of attending group activities. She stated she talked to someone when she first came to the facility and agreed on doing activities in her room. Resident #5 stated she has not seen that person anymore since she was admitted and did not recall the person name. She stated she thought the person worked with activities in the facility. Resident #5 stated she has not received activities in her room. She stated she would enjoy possibly doing an activity with someone outside just the two of them. Resident #5 also stated she would enjoy playing a game in her room. She denied being depressed or lonely. Resident #5 stated she has not been depressed in a long time. (she did not specify the length of time). She did not prefer to answer any further questions.Interview on 06/30/2026 at 2:00 p.m., the Activity Director stated Resident #5 was on the in-room activity program. She stated all residents were expected to have their care plan revised to meet their activity preferences. The Activity Director stated she did not revise Resident (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#5's care plan to meet their current activity preferences of receiving in-room activities. She stated she did not realize she did not revise Resident #5's care plan. She stated, if a resident was feeling lonely, had behavior issues or was depressed the staff would not have the information of the activities to use to help the resident.In an interview on 06/04/2026 at 3:00 p.m., The MDS Coordinator stated if a resident had a change in their activity preference the activity care plan was expected to be revised. He stated the Activity Director was expected to discuss the changes with the interdisciplinary team. He stated it was very important to revise any changes with the resident to the care plan. He stated the staff would not know what type of care or activities to do with the resident if the care plan was not updated to meet their current needs and preferences. He stated in-room activities were not on Resident #5's current care plan.In an interview on 06/30/2026 at 2:30 p.m., the Administrator stated his expectations of care plans was the IDT discussed care of each resident and if there was a change with anything which included resident preferences the care plan was expected to be revised. He stated the IDT was expected to ensure the resident's information to give appropriate care to each resident was documented on the care plan whether it was physical, emotional, resident preference, activities, etc. Record review of the facility's Comprehensive Care Plan, dated 2022, reflected It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS Assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for one of five residents (Resident # 9) reviewed for activities.The facility failed to provide Resident #5 in room activities three times per week from May 2026 through June 18, 2026.This failure could place residents at risk for boredom, depression, and a diminished quality of life.Findings includeRecord review of Resident #5's face sheet, dated 06/30/2026, reflected an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included cognitive communication deficit (an impairment in communication skills caused by disrupted thinking and mental processes- such as attention and memory rather than a primary speech issue), panic disorder (intense rush of physical and mental fear even when there is no actual danger or obvious trigger present), and age-related cognitive decline (the gradual, natural slowing of the brain processing and memory recall that occurs as people grow older. It may take slightly longer to learn new skills or multitask). Record review of Resident #5's admission MDS Assessment, dated 05/13/2026, reflected Resident #5 had a BIMS score of 15, which indicated her cognition was intact. Resident #5's activity preferences that were very important to her were the following:Having books, newspapers, and magazines to readBe around animals such as pets.Keep up with the newsGo outside to get fresh air when the weather was good.Record review of Resident #5's Comprehensive Care Plan, revised on 06/02/2026 reflected Resident #5 enjoyed visiting with family and talking on the phone. Intervention: Resident #5 preferred the following television channels: cooking shows.Record review of Resident #5's Activity Assessment, dated 06/07/2026 reflected Resident #5 preferred not to participate in group activities. Resident #5 received one on one (in room activities) three times per week. She enjoyed reading, watching television, the news, and coloring. Signed by the Activity Director.Record review of the list of residents on the in-room activity program, not dated, reflected Resident #5 was to receive in-room activities. Record review of the in room activity participation binder reflected Resident #5 did not have an in room activity participation record.During an observation and interview on 06/30/2026 at 1:00 p.m., revealed Resident #5 was lying in her bed. She was watching a talk show on television. Resident #5 stated she currently did not prefer to be in a group with other people. She stated she becomes nervous (feeling worried or slightly afraid, often accompanied by physical tension in the body) sometimes when she is around other people. Resident #5 stated she preferred for someone to do come to her room and do activities instead of attending group activities. She stated she talked to someone when she first came to the facility and agreed on doing activities in her room. Resident #5 stated she has not seen that person anymore since she was admitted and did not recall the person name. She stated she thought the person worked with activities in the facility. Resident #5 stated she has not received activities in her room. She stated she would enjoy possibly doing an activity with someone outside just the two of them. Resident #5 also stated she would enjoy maybe playing a game in her room. She denied being depressed or lonely. Resident #5 stated she has not been depressed in a long time (she did not specify the length of time). She did not prefer to answer any further questions.In an interview on 06/30/2026 at 1:30 p.m., CNA E stated if a resident was not receiving any type of activities there was a possibility a resident may become bored or lonely. She stated she knew who Resident #5 was and she did not recall observing anyone in Resident #5's room assisting with activities. She stated she had been working at the facility a approximately a year.In an Interview on 06/30/2026 at 8:15 a.m., the Activity Director stated Resident #5 was on the in-room activity program. She stated Resident #5 did not receive in-room activities since her admission to the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility few months ago. The Activity Director stated she did not recall the month Resident #5 was admitted to the facility. She stated , I forgot Resident #5 was to receive in room activities. The Activity Director stated if a resident was not receiving in-room activities there was a possibility a resident may become bored, feel isolated, and may have a decline in their mental status. She stated she was responsible to ensure all residents received the activities they needed. The Activity Director stated she had been an employee as Activity Director since 10/2023. She stated, I do not recall the exact date I was hired. The Activity Director stated Resident #5 did not have attend group activities very often. She stated Resident #5 was asked about her activity preferences when Resident #5 was admitted to facility. She stated Resident #5 activity preference was to have in room activities. Interview on 06/30/2026 at 9:52 a.m., the Administrator stated it was very important for the residents unable to come out of their room or unable to participate in group activities to receive activities in their room. He stated the Activity Director was over the activity department and he was the Activity Director's supervisor. He stated there was a possibility that a resident may become lonely if they were not receiving activities in their room. The Administrator stated he expected all activities to be documented on every resident on a daily basis to capture who was attending group activities and what the residents were doing during in-room activities. The Administrator stated anytime a resident was assessed by the Activity Director to receive in-room activities his expectations were the Activity Director to begin the in-room activities immediately and follow the resident's activity preferences. Requested Activity Policy on 06/30/2026 at 9:02 via email to the Administrator. In an interview on 06/30/2026 at 3:00 p.m. The Administrator stated the facility did not have an Activity Programming or documentation policy they followed the job description for the Activity Director. Record review of the Activity Job Description ,signed on 10/09/2023, reflected The Activity Director will be responsible for planning, coordinating, and directing the resident's activity program and the maintenance of necessary documentation. Essential functions such as :Organize both individual and group activities based on the needs of the residents.Provide activities for residents that are bedfast and/or unable to participate in group activities (one to one) and documents in the appropriate record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observations and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 6 residents (Resident #1) reviewed for pharmacy services. The facility failed to follow protocol of administering medications for Resident #1 resulting in postponing a surgical procedure. This failure could place residents at risk of not receiving the correct medications and a resident physical needs not being met. Findings included:Record review of Resident #1's face sheet, dated 6/30/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and, diagnoses included unspecified atrial fibrillation (the specific type or duration of the irregular heartbeat was not documented, often because the episode was new or being evaluated), need for assistance with personal care (support provided to individuals who cannot fully manage daily activities on their own, helping them maintain, hygiene, mobility, nutrition, and independence), and essential hypertension (high blood pressure with no identifiable secondary cause, often influenced by genetics, lifestyle, and age). Record review of Resident #1's admission MDS Assessment, dated 04/21/2026, reflected Resident #1 had a BIMS score of 8 which indicated his cognition was moderately impaired. Resident #1 did not have a feeding tube upon admission to the facility. Record review of Resident #1's Revised Care Plan, dated 06/29/2026 reflected as follows:*Resident #1 was on anticoagulant therapy (a type of drug that prevents blood clots from forming or getting larger) related to atrial fibrillation. On 06/23/2026: order received to stop Eliquis 48 hours prior to surgery. Interventions: Administer medication as ordered by Physician. Monitor side effects and effectiveness every shift. *Resident #1 had a Medi-port (a small device placed under the skin- usually on the upper chest. It connects to a flexible tube that leads directly to a large vein near the heart) inserted into the left subclavian (a major blood vessel that branches directly off the aortic arch) related to upcoming chemotherapy (a drug treatment used to destroy cancer cells, stop them from growing, or prevent them from spreading throughout the body). Interventions: Monitor Resident #1's Medi-port for 7 days (redness, swelling, or pain). Update the Physician of any changes in tone , color , swelling or pain to the Medi-port. *Resident #1 required tube feeding related to diagnosis of squamous cell carcinoma (the second most common form of skin cancer) with upcoming chemotherapy (a systemic drug treatment used to destroy cancer cells, stop them from growing, or prevent them from spreading throughout the body). Interventions: Provide local care to G-tube site as ordered and monitor for signs and symptoms of infection. Resident #1 needs assistance with tube feeding and water flushes. Record review of Resident #1's Physician Orders, dated 06/01/2026 thru 06/30/2026 reflected Resident #1 had an order of the following:Eliquis oral tablet of 5 MG give one table by mouth two times a day for atrial fibrillation with a start date of 04/17/2026 and an end date of 06/23/2026.2.Eliquis oral tablet of 5 MG give one table by mouth two times a day for atrial fibrillation with a start date of 06/25/2026 and an end date of 06/26/2026. Record review of Resident #1's Medication Administration Record (MAR), start date 06/26/2026 10:00 p.m. and end date 06/29/2026 at 9:19 p.m. reflected Resident #1 was NPO (nothing by mouth) on every shift. Surgery Monday (06/29/2026). Resident #1's medication Eliquis reflected:Eliquis oral tablet of 5 MG give one table by mouth two times a day for atrial fibrillation with a start date of 04/17/2026 and an end date of 06/23/2026.Eliquis oral tablet of 5 MG give one table by mouth two times a day for atrial fibrillation with a start date of 06/25/2026 and an end date of 06/26/2026. Record review of Resident #1's Nurses Practitioner Note, dated 06/17/2026, reflected Resident #1 was seen by Nurse Practitioner for monthly visit. This month he [Resident #1] had decided to undergo recommended treatment and a Porta Cath (a small implanted medical device placed entirely under the skin. It provides long-term, reliable access for intravenous treatments and blood draws), so (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he [Resident #1] can sustain nutrition and get chemo (a medical treatment that uses powerful drugs to destroy cancer cells). Diagnosis: Squamous cell carcinoma of skin, scalp and the neck. Squamous cell carcinoma of the neck as Tonsillar mass (a type of throat cancer that originates in the thin, flat lining of your tonsils) as evidence by biopsy after hospitalization on 04/22/2026. Record review of Resident #1's Nurse Practitioner Note, dated 6/23/2026 reflected Stopped his [Resident #1's] Eliquis (a bioprecipitation oral blood thinner medication that prevents and treats dangerous blood clots) oral tablet 5 mg BID 48 hours prior to surgery. Will restart when he returns.Record review of Resident #1's Nurses Note, dated 6/23/2026, reflected new orders received to hold Eliquis, Vitamin D3, Vitamin B12, and AREDS (high dose vitamin and mineral formulations clinically proven to slow the progression of age-related macular degeneration-eye disease that damages the central, most sensitive part of the retina) for two days prior to feeding tube procedure. Resident andResponsible Party were notified and verbalized understanding of the treatment plan. Signed by LVN A.Record review of Resident #1's Nurses Note, dated 06/25/2026, reflected LVN B called Nurse Practitioner regarding Resident #1's Eliquis. LVN B received an order to restart Eliquis 5 mg. and Nurse Practitioner will discharge the Eliquis at a later time. Resident #1 will probably have procedure on Monday (6/29/2026). Signed by LVN BRecord review of Resident #1's Nurses Note, dated 06/28/2026, reflected Resident #1 had no adverse effect from discontinuing Eliquis on 06/26/2026. Will continue to monitor any side effects or changes in behavior. Signed by LVN C.Record review of Resident #1's Nurses Note, dated 06/29/2026, reflected Resident #1 continued on NPO (nothing by mouth) since 11:00 p.m. for pending surgery of G-tube (a medical device surgically inserted through the abdomen directly to the stomach. It provides a direct channel to deliver nutrition, hydration, and medication to individuals who cannot eat or drink safely by mouth and Porta Cath. Signed by LVN C.Observation and interview on 06/30/2026 at 9:30 a.m. Resident #1 was lying in bed. Resident #1 stated I am not in any pain after I went to hospital yesterday [06/29/2026] for surgery. I had a tube placed in my stomach for feeding and something else called a catheter for me to get chemotherapy. I am tired and want to take a nap. He did not respond to any further questions.Interview on 06/30/2026 at 9:45 a.m. DON stated Resident #1 was scheduled to receive surgery on 06/26/2026 for a G-tube and a Porta Catheter. He stated the Nurse Practitioner discharged Resident #1's Eliquis for 6/24/2026 and 6/25/2026. He stated Resident #1 was to restart taking Eliquis once he returned from the procedure which was originally scheduled on 6/26/2026. DON stated Eliquis had been d/c from Resident #1's MAR on 06/23/2026. He stated Resident #1's Eliquis was not listed on the computer system the Nurses and Med-Aides use when administering medications. He stated Med-Aide D administered Eliquis on 06/24/2026 when the medication was to be held and had been d/c. DON stated during his investigation of why Resident #1 received Eliquis on 06/24/2026, it was determined Med-Aide D administered Eliquis to Resident #1 without reviewing the MAR in the computer system located on the medication cart. He stated if Med-Aide D had followed the medication administration protocol of the facilities policy, she would have known not to give Resident #1 his Eliquis. He stated it was the expectation and part of the medication administration to review the MAR and compare the medication on the MAR with the medications being administered to the resident. He stated this was the only medication Med-Aide D gave to Resident #1 when she made the medication error. Interview on 06/30/2026 at 10:30 a.m. Med-Aide D stated she did not review Resident #1's MAR on the computer system located on top of the medication cart prior to giving the medication Eliquis to Resident #1 on 06/24/2026. She stated she was expected to have the medication cart with her at residents room, Identify the resident, review the MAR and compare medications to the MAR, explain the medication to the resident, take blood pressure if needed, and observe Resident #1 swallow his medications. She stated Resident#1 was only to receive Eliquis at the time she administered the medication to him and she did not follow protocol. She stated if she had reviewed the MAR on the computer system she would have known the Eliquis had been discharged . Med-Aide D stated later she realized she made a mistake and contacted the DON and reported the med error to DON. She stated LVN A contacted the Nurse Practitioner, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1, Resident #1's responsible party about giving him Eliquis. She stated the procedure to have G-tube and Porta Cath was postponed until Monday 06/29/2026. She stated Resident #1 was expected to have this procedure on Friday 06/26/2026, however, since he received the Eliquis by error the procedure had to be postponed. She stated she was inserviced and trained on medication administration prior to the med error and after the med error of given Eliquis to Resident #1 when the medication had been d/c. Interview on 06/30/2026 at 2:18 p.m. Nurse Practitioner stated Resident #1 did not have any adverse effects from his medication Eliquis. She stated there was no adverse effect from the surgical procedure of the G-tube and Porta Cath delayed from Friday 06/26/2026 until 06/29/2026. She stated he was doing great and currently there was no concerns about his G-tube , Porta Cath or any of his medications. Interview on 06/30/2026 at 2:30 p.m. The Administrator stated his expectations was all Med-Aides and Nurses to follow the facility policy and protocol when administering medications. He stated Med-Aide D did not follow the facility's protocol when she administered Eliquis to Resident #1. He stated Med-Aide D had been counseled, one-on-one in-service and training was completed with her and will continue training and observations of Med-Aide D administering medications. He stated all Med-Aides and Nurses received in-service on administering medications and following the facility's policy. The Administrator stated he was not a medical profession, and he could not answer any questions concerning the medication and any medical information. Record review of the Facility's Policy on Medication Administration, dated 10/24/2022 reflected the following: Policy:Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Policy Explanation and Compliance Guidelines: 10. Review MAR to identify medication to be administered. 14. Administer medication as ordered in accordance with manufacturer specifications. 20. Correct any discrepancies and report to nurse manager.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to 1 of 3 medication carts (Medication Cart #1) reviewed for drug storage.The facility failed to ensure LVN A did not leave Medication Cart #1, unlocked leaving , medications unsecured, and accessible to other staff, residents, or visitors on 06/23/2026 at 6:49 a.m. and 7:30 a.m.This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications.Findings included Observation on 06/30/2026 at 12:56 a.m., revealed Medication Cart #1 was facing toward the open area between the med room and the nurses' station. There were not any staff in the hall or near the nurse's station. LVN A exited Hall E approximately 1:05 a.m. and walked toward the nurse's station to the observed unlocked medication cart.Interview with LVN A on 06/30/2026 at 1:09 a.m., stated she was trained on medication storage. She stated the nurse or medication aide who was working on the cart was responsible for locking the medication cart. LVN A stated if the staff left the medication cart unlocked and unattended a resident, staff or a visitor could get into the medication cart and take medication that did not belong to them. LVN A stated there was a possibility that a resident may have an allergic reaction if ingested medication ordered for another resident. She stated it was a possibility a resident may need to be transferred to emergency room for an evaluation. She stated she had been in-serviced on locking medication carts however; she did not recall the date or time. Interview with the Director of Nurses on 06/30/2026 at 3:00 p.m., he stated all medication carts were expected to be locked when the med-aide or nurse was not standing in front of the medication cart. He stated if the medication cart was left unlocked and unattended, a resident could get into the medication cart and take medications. He stated there was a possibility a resident may become severely ill such a low blood pressure if the resident ingested numerous blood pressure pills. He stated a resident may need to be admitted to hospital for further evaluation. He stated nurse leadership was to monitor by doing observations and in-service training. He stated she did not know why LVN A left the medication carts unlocked on 06/30/2026.Interview with the Administrator on 06/23/2026 at 9:45 a.m., stated the medication cart was to always be locked. He stated no matter what time of day the medication cart should be locked. He stated the nurse or medication aide who was on the medication cart were responsible for ensuring the medication cart was locked. The Administrator stated if the medication cart was left unlocked and unattended a resident could take medication that was harmful to them and the resident may need medical attention from the hospital. He stated he did not know why LVN A left the medication cart unlocked. He stated the staff had received in-services on locking medication cart. Record review of the Facility's Policy on Medication Carts and Supplies for Administering Meds, dated 10/01/2019 reflected Only a Licensed Nurse or Certified Medical Aide may carry keys to the medication cart. The medication cart is locked at all times when not in use.