

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Bastrop Lost Pines Nursing and Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 430 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176</p> <p>comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible for five of sixteen (room [ROOM NUMBER], 307, 313, 315, and 316) rooms reviewed for environmental conditions.</p> <p>1) The facility failed to securely attach a sink basin to the wall, which ensured that the sink did not move or fall off in room [ROOM NUMBER].</p> <p>2) The facility failed to ensure the wall in room [ROOM NUMBER] was free from black scuff marks and large patches of peeling paint.</p> <p>3) The facility failed to ensure the bed in room [ROOM NUMBER] had a footboard to prevent the mattress from sliding down and off the bed.</p> <p>4) The facility failed to ensure the window in room [ROOM NUMBER] and room [ROOM NUMBER] closed properly without a gap to the outside to ensure proper room temperature could be held and to protect the residents from potential of vandalism or break-in.</p> <p>These failures could place residents at risk of living in an unsafe, unhomelike, and uncomfortable environment.</p> <p>Findings included:</p> <p>1. Observation and interview on 12/03/2024 at 10:35 AM, revealed room [ROOM NUMBER]'s bathroom sink basin was detached from the wall and there was approximately a 1-inch gap from the basin to the wall on the top and sides of the sink. The sink moved when the sink was pressed down. Resident #55 stated the sink had been like that for months and she called the maintenance director several times and never got a response. Resident #55 did not use the sink as she was dependent on staff for all her activities of daily living. Resident #67 stated she stopped using the sink for fear of getting hurt because the sink was detached from the wall . She did not like the condition of the sink and wanted it repaired.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 12/04/2024 at 8:16 AM, revealed room [ROOM NUMBER]'s bathroom sink basin was detached from the wall and there was approximately a 1-inch gap from the basin to the wall on the top and sides of the sink. Resident #55 stated the Maintenance Director came to work on the sink on 12/03/2024 but told the resident he did not have a sink to replace it and would return later to repair it. Resident #55 stated the Maintenance Director told her to be careful when using the sink .</p> <p>During an observation and interview on 12/04/2024 at 03:12 PM, the Maintenance Director stated he repaired the sink in room [ROOM NUMBER] this morning after the ADM told him about it on 12/02/2024. room [ROOM NUMBER]'s bathroom sink was observed to be fully attached to the wall with new caulking around the basin. The Maintenance Director stated the sink would be considered a critical task that would be repaired immediately because of the safety concern. If the resident applied too much pressure, the sink could fall and cause bodily injury. He stated Resident #67 was in a wheelchair and the sink could fall and break a toe. The Maintenance Director stated he did rounds in residents' rooms often as part of his daily work but would not say how often that was. The Maintenance Director was new to his position and only been at the facility for a couple of months . He relied on staff to put in work orders. He stated residents could make maintenance requests for repairs by telling a staff member, who then created a work order using a Kiosk system that went to the Maintenance Director's phone and computer as work orders . He would review the work orders and prioritize the work and did the work per hallway. Time for repairs varied depending on how critical the task was.</p> <p>During an interview on 12/05/2024 at 10:05 AM, CNA J stated she was not aware of the sink in room [ROOM NUMBER]. She assisted Resident #67 to the bathroom. CNA stated that the sink coming away from the wall would be a safety concern if either resident put any weight on the sink because it could fall and hurt the resident. If she had noticed it, she would have reported it to the nurse.</p> <p>Record review of open and closed work orders provided by the ADM showed no order history for the sink repair. Record review of the work order for the sink repair in room [ROOM NUMBER], provided by the Maintenance Director on 12/04/2024 at 04:00 PM, reflected it was created on 12/04/2024 at 3:49 PM by the Maintenance Director with a due date of 12/02/2024 .</p> <p>2. Observation on 12/03/2024 at 09:53 AM, revealed room [ROOM NUMBER]'s left side of the wall between bed A and bed B had several black scuff marks which extended along the entire bottom of the wall in the middle of the room above the baseboard. Several areas of paint were peeled off the wall which exposed the white sheetrock. Resident #26 was observed asleep in wheelchair in room and unavailable for interview. The other resident in the room was in the hospital and was not available for interview.</p> <p>During a telephone interview on 12/04/2024 at 01:16 PM, Resident #26's family member stated she had seen the scuff marks and missing paint and thought that was due to the roommate's wheelchair. She stated she had not reported it to staff, but wanted it repaired. She stated Resident #26's vision was poor and probably hasn't noticed the scuff marks and missing pain. She stated Resident #26 currently had an urinary tract infection and was confused and would not be able to answer questions.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/04/2024 at 03:12 PM, the State Surveyor showed the Maintenance Director room [ROOM NUMBER]. The Maintenance Director stated he was not aware of the wall issue with the scuff marks and peeling paint. He stated it was probably due to the roommate's wheelchair and had been like that for a while. He stated the paint was peeling off and he would not consider that a homelike environment. He would not want his mother or grandmother in a room like that. He checked the computer system and did not find a work order .</p> <p>During an interview on 12/05/2024 at 10:05 AM, CNA J stated she had had not noticed the scuff marks and peeling paint but said that was not homelike.</p> <p>3. Observation and interview on 12/03/2024 at 11:51 AM, revealed room [ROOM NUMBER] had a mechanical bed without a footboard. Resident #43 stated it took the facility weeks to respond to a maintenance request . She stated the mattress slides off the bed.</p> <p>Observation and interview on 12/05/2024 at 09:36 AM, revealed Room#315's bed had a footboard . Resident #43 stated her bed had been missing the footboard for approximately 3 to 4 weeks. She reported it to the Administrator and to several unnamed staff members that she could not identify. Resident #46 stated the mattress would slide around while she was lying in the bed, and she was afraid of falling off the bed . She had never fallen off the bed due to not having a footboard. She stated she received a new bed with a footboard on 12/03/2024 and she felt safe .</p> <p>Record review of closed work orders revealed there was no specific order for a footboard.</p> <p>During an interview on 12/04/2024 at 03:12 PM, the Maintenance Director stated he was aware of several concerns regarding the beds on hall 300. There had been a delay in maintenance repairs because he was recently hired and getting caught up on all the repairs.</p> <p>Interview on 12/05/2024 at 12:41 PM, the ADM stated Resident #43 complained about a lot of things in her room and can get fixated on her concerns. The ADM stated any staff members could report a maintenance repair concern. The ADM stated that they did not have a Maintenance Director for about two weeks and had to hire a new one and this created a delay in some maintenance requests being completed.</p> <p>4. Observation and interview on 12/03/2024 at 12:47 PM, revealed room [ROOM NUMBER]'s windowsill had a rolled towel along the base of the window. The window had a small gap appropriately 1/2 inch on the left side of the window and would not close completely. Resident #72's AR stated the window did not close all the way and the room got cold due to the gap in the window. The AR reported it to the Maintenance Director at the end of September 2024, but it had not been repaired . The ambient temperature in the room felt comfortable to the State surveyor and Resident #72 was observed to be appropriately dressed. Resident #72 was not interviewable.</p> <p>Observation and interview on 12/03/2024 at 03:31 PM, Resident #84 was observed lying in bed wearing a t-shirt and brief. Resident #84 was non-verbal but could nod in response to yes and no questions. He nodded yes that he was aware of the window problem, and it bothered him. He wanted it repaired. Resident #84 nodded no when asked if he or the room was cold.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/04/2024 at 08:11 AM, revealed room [ROOM NUMBER]'s windowsill had a rolled towel along the base of the window. The window had a small gap appropriately 1/2 inch on the left side of the window and would not close completely. A cold draft could be felt by the window. The outside temperature was appropriately 53 degrees Fahrenheit according to a weather app, but the inside of the room felt comfortable.</p> <p>During an interview on 12/04/24 at 03:23 PM the State Surveyor showed the Maintenance Director room [ROOM NUMBER]'s window. The Maintenance Director stated he was not aware of any problem with the window. He looked at the window and said there was a small piece of plastic and a string in the bottom left corner of the window that was preventing the window from closing all the way. He stated he checked all the windows two weeks ago and had not noticed it. The Maintenance Director stated the concern would be the draft/weather could cause temperature changes in the room, and someone might try to vandalize or break into the room. He checked the computer system and did not find a work order .</p> <p>Observation and interview on 12/05/2024 at 11:56 AM, revealed room [ROOM NUMBER]'s windowsill had a rolled towel along the base of the window. The towel was dirty with what appeared to be dirt and was slightly damp. The window had a small gap appropriately 1/2 inch that a pen would fit in along the entire window and would not close completely. A cold draft could be felt coming in from the window. The outside temperature was appropriately 55 degrees Fahrenheit according to the weather app on the surveyor's state issued cell phone . Resident #80 was observed wearing gloves. She stated she did not put the towel there and did not know how long it had been there . Resident #80 appeared confused and was not able to answer specific questions about the window.</p> <p>Interview on 12/05/2024 at 08:20 AM and 12:41 PM, the ADM stated he was aware of the delays in maintenance repairs due to problems with the prior Maintenance Director not completing repairs timely. The facility had a mock survey that brought this concern to their attention, and they had an Ad Hoc QAPI meeting on 11/05/2024 to discuss the maintenance repair concerns. Due to these concerns, the previous Maintenance Director was asked to leave, and the facility hired a new Maintenance Director because it was taking a long time to do any repairs. Due to the Ad Hoc QAPI meeting, the new Maintenance Director went through the entire building using a systematic approach to identify maintenance concerns. When asked if the ADM identified priority items that needed to be repaired that would impact a resident's safety, the ADM stated no, they used the systematic approach. The ADM stated there was no formal policy on how soon to respond to work orders and there was no policy on maintenance repairs. The ADM stated he utilized a preventative maintenance program. The ADM stated critical items would be repaired that could possibly harm a resident and should be addressed as soon as possible, such as the sink in room [ROOM NUMBER]. High priority repairs could cause harm and should be handled quickly, such as next day if possible. The delay in maintenance repairs would not be homelike. The ADM stated the concern with the windows in room [ROOM NUMBER] and #316 could affect the room temperature, especially since it was cold outside. The ADM stated during their transition when hiring a new Maintenance Director, they did not have a Maintenance Director for about two weeks and that caused a delay in repairs.</p> <p>Record review of grievances for the last three months did not show any maintenance delay grievances related to these specific concerns.</p> <p>(continued on next page)</p>		

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