

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  11/18/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review the facility failed make sure that drugs are stored properly and only authorized persons have access for 1 of 4 medication carts (MC #1) reviewed for drug storage and labeling. The facility failed to ensure the 300-hall medication cart was locked and medications were secured and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings Included: Observation of 300-hall on 10/07/2025 at 8:25 a.m., revealed MC #1 was unattended and unlocked. MA A was at the nurses station talking to another staff member with her back turned away from the cart. The medication cart was up against the wall by the dining room entrance. The locking mechanism was protruding outward on the medication cart. The cart contained prescribed medication for residents' and over the counter medications. The state surveyor opened drawers and captured pictures. MA A did not see the surveyor open the drawers and take pictures. During an interview on 10/07/2025 at 8:30 a.m., revealed MA A had been trained on medication storage. She said the policy was to make sure the medication cart was locked when staff were away from the cart. She said the medication cart must always be locked when not giving out medication. She said she was responsible for ensuring the medication cart was locked. She said if a medication cart was left unlocked and unattended then a resident could get into the medication cart. She said she forgot to lock the cart because she got distracted. During an interview with the DON on 10/02/2025 at 11:01a.m., revealed she had only been working at the facility for four days. She said staff had been trained in medication storage. She said she did not know what the policy was for medication storage. She said she expected staff to follow the policy. When asked how she would know if staff were following the policy since she did not know she said they could ask what the policy was. She said the person on the medication cart was responsible for ensuring the medication cart was locked. She said the medication cart was to be locked when staff were not using the medication cart. She said if the medication cart was left unattended and unlocked a resident or anyone who was not authorized to pass medication could get into the cart. She said the DON and charge nurse were responsible for monitoring to ensure the medication carts were locked. She said it was monitored by observations. She said MA A did not lock the cart because a resident called her and she forgot. During an interview with the ADM on 10/07/2025 at 2:35 p.m., revealed he and staff have been trained on medication storage. He said the policy for the medication cart was that the medication cart was to be locked when the nurse or MA were not next to the cart. He said the nurse or MA using the medication cart was responsible for ensuring the cart was locked. He said if the medication cart was left unattended and unlocked, someone who is not supposed to get in the medication cart could get into the cart. He said all managers monitored to ensure the medication carts were locked. He said the managers monitored by line of sight. He said the lock would stick out and it was easy to see if the medication cart was unlocked. He said MA A left the medication cart unlocked because she was asked a question and walked away. Record review of Medication Administration: Medication Carts and Supplies for Administering Medication Policy revised 10/01/2019 revealed: Procedure: 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. Do not leave the medication cart unlocked or unattended in the resident care areas. Preferably, the medication cart is stored in the Medication Room when not in use.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and record review the facility failed make sure that drugs are stored properly and only authorized persons have access for 1 of 4 medication carts (MC #1) reviewed for drug storage and labeling. The facility failed to ensure the 300-hall medication cart was locked and medications were secured and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings Included: Observation of 300-hall on 10/07/2025 at 8:25 a.m., revealed MC #1 was unattended and unlocked. MA A was at the nurses station talking to another staff member with her back turned away from the cart. The medication cart was up against the wall by the dining room entrance. The locking mechanism was protruding outward on the medication cart. The cart contained prescribed medication for residents' and over the counter medications. The state surveyor opened drawers and captured pictures. MA A did not see the surveyor open the drawers and take pictures. During an interview on 10/07/2025 at 8:30 a.m., revealed MA A had been trained on medication storage. She said the policy was to make sure the medication cart was locked when staff were away from the cart. She said the medication cart must always be locked when not giving out medication. She said she was responsible for ensuring the medication cart was locked. She said if a medication cart was left unlocked and unattended then a resident could get into the medication cart. She said she forgot to lock the cart because she got distracted. During an interview with the DON on 10/02/2025 at 11:01a.m., revealed she had only been working at the facility for four days. She said staff had been trained in medication storage. She said she did not know what the policy was for medication storage. She said she expected staff to follow the policy. When asked how she would know if staff were following the policy since she did not know she said they could ask what the policy was. She said the person on the medication cart was responsible for ensuring the medication cart was locked. She said the medication cart was to be locked when staff were not using the medication cart. She said if the medication cart was left unattended and unlocked a resident or anyone who was not authorized to pass medication could get into the cart. She said the DON and charge nurse were responsible for monitoring to ensure the medication carts were locked. She said it was monitored by observations. She said MA A did not lock the cart because a resident called her and she forgot. During an interview with the ADM on 10/07/2025 at 2:35 p.m., revealed he and staff have been trained on medication storage. He said the policy for the medication cart was that the medication cart was to be locked when the nurse or MA were not next to the cart. He said the nurse or MA using the medication cart was responsible for ensuring the cart was locked. He said if the medication cart was left unattended and unlocked, someone who is not supposed to get in the medication cart could get into the cart. He said all managers monitored to ensure the medication carts were locked. He said the managers monitored by line of sight. He said the lock would stick out and it was easy to see if the medication cart was unlocked. He said MA A left the medication cart unlocked because she was asked a question and walked away. Record review of Medication Administration: Medication Carts and Supplies for Administering Medication Policy revised 10/01/2019 revealed: Procedure: 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. Do not leave the medication cart unlocked or unattended in the resident care areas. Preferably, the medication cart is stored in the Medication Room when not in use.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review facility failed to provide comfortable and safe rooms for residents for 4 of 11 residents (Resident #1, Resident #2, Resident #3, and Resident #4) reviewed for environment. The facility failed to ensure Resident #1, Resident #2, Resident #3, and Resident #4's bedroom floor was clean from trash, food crumbs and a dried spilled substance that appeared to be coffee. Resident #4's bathroom had a brown substance around the base of the toilet, used paper towels on the resident's bathroom floor, and a half black ring in the toilet. The failure could place residents at risk of living in an uncomfortable and unsafe environment, decreased feelings of self-worth, and a diminished quality of life. Findings included: Resident #1 Record review of Resident #1's face sheet dated 10/07/2025 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included mononeuropathy of left lower limb (damage that occurs to a single nerve causing pain, loss of movement and numbness), heart disease, chronic kidney disease stage 4 (a serious condition where the kidneys are severely damaged), heart failure and absence of right leg above the knee. Record review of Resident #1's quarterly MDS dated [DATE] revealed Resident #1 had a BIMS of 11 which indicated moderate impairment. The MDS also revealed Resident #1 was partial/moderate assist with sit to stand, lower body dressing and transfers. Resident #1 was supervision/touching assist with mobility. Record review of Resident #1's care plan dated 08/24/2025, revealed Resident #1 had limited physical mobility r/t decreased physical strength, right above the knee amputation. The care plan also said Resident #1 required Supervision/touching assistance to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. Resident #2 Record review of Resident #2's face sheet dated 10/07/2025 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included muscle wasting, abnormalities of gait and mobility, lack of coordination, repeated falls, ankylosis left knee (severe stiffness in the knee that can cause partial restricted movement or complete immobility), presence of artificial left knee joint, fracture of right side one rib, and hip fracture. Record review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 had a BIMS of 02 which indicated severe cognitive impairment. The MDS also revealed Resident #2 was substantial/ maximal assistance with sit to stand, lower body dressing and transfers. Resident #2 was partial/moderate assist with mobility. Record review of Resident #2's care plan dated 08/27/2025, revealed Resident #2 required substantial/maximal assistance to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. Resident #3 Record review of Resident #3's face sheet dated 10/07/2025 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included muscle wasting, need for assistance with personal care, heart failure, depression (a persistent feeling of sadness), and absence of left leg above the knee. Record review of Resident #3's annual MDS dated [DATE] revealed Resident #3 had a BIMS of 07 which indicated severe cognitive impairment. The MDS also revealed Resident #3 was dependent on staff for lower body dressing and transfers. Resident #3 was substantial/maximal assistance with mobility. Record review of Resident #3's care plan dated 07/21/2025, revealed Resident #3's functional performance for picking up objects was marked as not applicable. Resident #4 Record review of Resident #4's face sheet dated 10/07/2025 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included right and left artificial shoulder joint, disease of musculoskeletal system and connective tissue (type of cancer that can start in your connective tissue), shortness of breath, chronic kidney disease stage 3 (a serious condition where the kidneys are severely damaged), osteoporosis (disease that weakens the bones and make them more likely to break), and atrial premature depolarization (extra heartbeats that start in the upper chamber of the heart) Record review of Resident #4's annual MDS dated [DATE] revealed Resident #4 did not have a BIMS score. The MDS also revealed Resident #4's functional abilities were not completed. Record review of Resident #4's baseline care plan dated 10/06/2025, revealed Resident #4's cognitive status was cognitively intact. The care plan also said the resident had impaired balance and unsteady gait requiring supervision. Resident was a partial/moderate assistance with transfers. Observation of Resident #1's room on 10/07/2025 at 8:31a.m., revealed the floor had brown spots that appeared to be dried spilled coffee, pieces of eggs, and sugar packet trash on the floor. Observation of Resident #3's room on 10/07/2025 at 8:36 a.m., revealed the floor had a used napkin and a used paper towel wadded up on the floor. Observation Resident #2's room on 10/07/2025 at 11:23am revealed that there</p>		