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 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of six residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was not A. verbally and mentally abused when she was told to shut up, she was nasty, she should be in a psych ward or be demeaned and ridiculed by LVN A, CNA A, and CNA B making her cry as seen on Resident #1's room video footage on 03/08/2026. B. told to walk from her bathroom to her bed with minimum assistance from CNA A and not provided a wheelchair by LVN A and CNA B when Resident #1 asked for her wheelchair resulting in Resident #1 falling and hitting her knee on the bathroom floor as seen on Resident #1's room video footage on 03/08/2026 The noncompliance was identified as Past Noncompliance. The Immediate Jeopardy (IJ) began on 03/08/2026 and ended on 03/13/2026. The facility had corrected the noncompliance before the survey began.Finding included: Record review of Resident #1's face sheet, dated 03/18/2026, revealed a seventy-five-old female who was admitted to the facility on [DATE]and re-admitted [DATE]. Her admitting diagnoses included moderate intellectual disabilities (a neurodevelopmental condition characterized by an IQ between 35-49, significant developmental delays, and a need for ongoing support with daily tasks), vascular dementia, moderate without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (indicates a moderate stage of vascular-related cognitive decline where the resident requires frequent assistance with daily activities but does not exhibit significant psychiatric or behavioral symptoms), and bipolar disorder (a chronic mental health condition characterized by extreme, often debilitating shifts in mood, energy, and activity levels, alternating between manic highs and depressive lows). Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 12/17/2025 Quarterly Comprehensive Section C - Cognitive Patterns revealed a score of 7 indicating severe cognitive issues, Section GG Functional Abilities - mobility device wheelchair. Record review of Resident #1's care plan revealed a focus dated 02/29/2026 reflected Resident #1 had ADL self-care performance deficit related to dementia, moderated intellectual disabilities, DM2 (adult-onset multisystem disorder characterized by muscle weakness, pain, and stiffening often affecting the hips, thighs, and neck), and tremors with the following interventions: Intervention dated 06/02/2025 functional performance: Resident #1 could not take 4 steps.Intervention dated 06/25/2025 functional performance: chair/bed-to-chair transfer: Resident #1 required supervision/ touching assist to transfer to and from a bed to a chair (or wheelchair)Intervention dated 06/02/2025 functional performance: sit to stand: Resident #1 required supervision/touching assist to come to a standing position from sitting in a chair, wheelchair, or on the side of the bedIntervention dated 06/02/2025 functional performance: toilet transfer: Resident #1 required partial/moderate assist to get on and off a toilet or commode.Intervention dated 06/02/2025 functional performance: toileting hygiene: Resident #1 required partial/moderate assist for toileting hygiene Intervention dated 06/02/2025 functional performance: toilet use: Resident #1 required extensive assist x1 staff for toiletingIntervention dated 06/02/2025 functional performance: transfer: Resident #1 required (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

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 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	extensive assist x1 staff to move between surfaces and as necessary Record review of Resident #1's care plan revealed a focus dated 02/21/2025 Resident #1 had communication problem related to hearing deficit, usually understood/understands/speech unclear with intervention dated 01/22/2022 allow adequate time to respond, repeat as necessary, do not rush, request clarification from Resident #1 to ensure understanding, face when speaking, make eye contact, use simple brief consistent words/clues, ensure safe environment. Record review of Resident #1's care plan revealed a focus dated 11/24/2022 and revised 03/13/2026 reflected Resident #1 had attention seeking behaviors of sitting in her wheelchair and crying with interventions dated 04/21/2026 if reasonable. Discuss Resident #1's behavior - explain/reinforce why behavior was inappropriate and/or unacceptable to Resident #1 and intervene as necessary to protect the rights and safety of others. - approach/speak in a calm manner, divert attention, remove from the situation and take to alternate location as needed. Observation of video 1 of 8 dated 03/08/2026 2:02 minutes revealed LVN A outside the door of Resident #1's bathroom. Resident #1's in her bathroom sitting in her wheelchair facing toward the toilet with her right arm towards the grab bar. LVN A's was talking on a cell phone for approximately 3 minutes with her back towards Resident #1. Resident #1's bathroom was to the right of LVN's back and Resident #1's bed to the left of the back of LVN A with a wall separating the bathroom and the bedroom. LVN A was outside of video surveillance from 0:03 through 0:43. LVN A re-entered Resident #1's bathroom at 0:43 and said, come on [Resident #1] you're going to have to stand up I can't lift you. LVN A turned Resident #1's wheelchair to face the grab bar. Resident #1 pulled herself to a standing position from her wheelchair at 0:54 holding the grab bar. LVN A was standing behind Resident #1. LVN A said, yup, I know you can stand up, doing all that faking. LVN A had an adult brief in her hand and attempted to put the adult brief on Resident #1 while Resident #1 was standing and holding the grab bar. Resident #1 defecated and LVN A stated, at 1:02 Eww, [Resident #1's first name], gross. Resident #1 was giggling. LVN A did not put the brief on Resident #1 put and moved it away from Resident #1. LVN A said Jesus Christ, yea, I'll be right back. LVN A walked out of the bathroom at 2:02 and said, oh my God. Resident #1 was standing at the grab bar in from of her wheelchair with no adult brief, and no clothing from the waist down. At 1:39 Resident #1 used her left hand to hold on to the grab bar and her right arm to grapple to locate the right arm of the handle of the toilet seat to lower herself from the grab bar and sat down hard on the toilet. Video ended with Resident #1 on the toilet seat alone in her restroom. Observation of video 2 of 8 from 03/08/2026 2:05 minutes revealed Resident #1 on the toilet alone in her bathroom from 0:00 through 1:39. At 1:39 LVN A entered Resident #1's room. LVN A stood outside of Resident #1's bathroom pointed to Resident #1 in the bathroom with the door open in Resident #1's hearing distance and said, (unintelligible) and she [Resident #1] thinks it's so fucking funny. LVN A was speaking to CNA A who was out of camera view. LVN A told CNA A, I stood her up to put her diaper on like she [Resident #1] asked me to and she shit everywhere and shit on me and she [Resident #1] thinks it is funny. Video ended with Resident #1 on the toilet in her restroom. Observation of video 3 of 8 from 03/08/2026 1:05 minutes revealed Resident #1 sitting on the toilet in her bathroom. LVN A was standing outside of Resident #1's bathroom talking to CNA A. LVN A stated to CNA A, who was not visible in the video, that one won't bring her home or deal with her cause this well I mean think about it (unintelligible) gripe at us about getting irritated with this but this shit we are supposed to let this go we are just supposed to let her [Resident #1] act like that CNA A said, yea, she [Resident #1] knows better. LVN A said, yea, she [Resident #1] does and that's why [Resident #1] thinks it's funny and now we are just supposed to laugh it off and let it go so that's not fair. CNA A stated, it's a behavior problem. LVN A said, exactly and she [Resident #1] gets to hit people and put her hands on people. CNA A said, she [Resident #1] better not. LVN A said, oh she [Resident #1] does. LVN A said, oh she [Resident #1] does she [Resident #1] can grab my [unintelligible] one day and hit me in the head. When Resident #1 was seen in the video sitting on the toilet and touched her vagina CNA A said, stop touching yourself it's nasty, you need a psych hospital. LVN A said, that's exactly what she [Resident #1] (continued on next page)

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 03/20/2026
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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	needs. Observed that Resident #1 was sitting on the toilet making no noise. Video reflected Resident #1's bathroom door remained open during the dialog between CNA A and LVN A. Video ended with Resident #1 sitting on the toilet in her bathroom. Observation of video 4 of 8 from 03/08/2026 1:06 minutes revealed at 0:07 LVN A entered the open door to Resident #1's bathroom and removed Resident #1's wheelchair from the bathroom. After LVN A removed Resident #1's wheelchair LVN A re-entered Resident #1's bathroom with Resident #1 sitting on the toilet and LVN A said, nastiest shit I have ever seen in my life and you [Resident #1] think it's fucking funny. Yea, it's funny alright if you're not the one who has to clean it up I guess you think it's funny but it's not none of it's funny it's shameful you should be ashamed of yourself lift your foot. (LVN A was observed using a wipe to clean the bathroom floor below Resident #1's feet when Resident #1 was on the toilet). At 0:55 LVN A left Resident #1's room and Resident #1 was on the toilet. Observation of video 5 of 8 from 03/08/2026 2:05 minutes revealed Resident #1 on the toilet in Resident #1's room and LVN A in Resident #1's bathroom using wipes and wearing gloves to clean up the floor of Resident #1's restroom. At 0:10 Resident #1 began making sounds like sobbing. At 0:47 as LVN A cleaned the floor at Resident #1's feet when Resident #1 was sitting on the toilet Resident #1 was making sounds like crying and LVN A said, stop crying what are you crying for shit what are you crying for shitting yourself, holy shit intelligible nice to you ever when you do shit like this that's for fucking Resident #1 began making sound like crying again. LVN A said, stop crying. I'm the one who should be crying. At 1:38 LVN A used wipes to clean Resident #1's feet while Resident #1 was sitting on the toilet. LVN A picked up Resident #1's clothing and left Resident #1's restroom and told Resident #1, you need to be in the psych ward, I got all this shit off the floor. At 1:56 CNA B entered the room and said, you know she does that on purpose. LVN A said, I know she [Resident #1] does. CNA B entered Resident #1's bathroom. CNA B's back was to the camera. LVN A said, while Resident #1 was on the toilet in the bathroom I told [Resident #1] she should be ashamed of herself it's a total behavior thing and CNA B said, yea, I know, and then she sits there and cries. Video ended with Resident #1 sitting on the toilet in her bathroom sobbing. Observation of video 6 of 8 from 03/08/2026 1:19 minutes revealed Resident #1 sitting on the toilet sobbing. CNA was in the bathroom with Resident #1. LVN A said, I have to clean her wheelchair off she got shit off on that too. CNA said, what we can do is we can put her [Resident #1] in the bed, and we can put it out there and wash it tonight. I can power spray it tonight but that means she won't have a wheelchair, but she doesn't need a wheelchair. LVN A said, that's what she [Resident #1] gets for shitting all over it. CNA B said, She [Resident #1] thought it was funny. CNA B said, you're nasty quit touching yourself down there. At 0:55 LVN A and CNA B left Resident's room with Resident #1 on alone in her bathroom sitting on the toilet sobbing. LVN A re-entered Resident #1's bathroom at 1:03. Resident #1 was sitting on the toilet and CNA B said, get up. The door to the bathroom shuts and CNA B tells Resident #1, get up. At 1:10 the door to the bathroom with Resident #1 and CNA B inside was closed unable to see or hear Resident #1 or CNA B. At 1:17 door to Resident #1's bathroom was closed and can hear CNA B saying. shut up. Observation of video 7 of 8 from 03/08/2026 2:05 minutes revealed door to Resident #1's bathroom was opened by LVN A. Resident #1 was standing holding the grab bar to the left of the toilet and CNA B was putting a brief on Resident #1 while Resident #1 was standing. LVN A was in the bathroom with Resident #1 and CNA B. Resident #1 was crying and LVN A said, cry cry cry, shut up, just seriously shut up. Resident #1 continued to cry. CNA B said, you [Resident #1] do this every day and you think it's funny and it's not. LVN A said, if you go to the psych ward you won't think it's funny, standup stand over there you have shit on your leg. You should cry, nasty. You ain't getting your chair. Resident #1 was sobbing; Resident #1 was standing facing the door and CNA was holding Resident #1's right arm about 4 inches above Resident #1's elbow to support Resident #1. CNA B said, you're walking, hush come walk. Resident #1 said, no. CNA B said, yes ma'am. CNA B continued to hold Resident #1's right arm about 4 inches above her elbow. Resident #1 sobbed, attempted to take a step, fell, and Resident #1's left knee hit the floor at 1:59. Resident #1 continued to sob and was sitting on the floor for the (continued on next page)

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 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	remainder of the video comments by LVN A and CNA B unintelligible. Observation of video 8 of 8 from 03/08/2026 1:59 minutes revealed Resident #1 on the floor of her bathroom sobbing with CNA B to the right of Resident #1 and LVN A standing in front of Resident #1. CNA B said, you are not going to get your chair you know how to walk get up. CNA B got behind Resident #1, and lifted Resident #1 to a standing position. LVN A did not assist Resident #1 or assess Resident #1 and told Resident #1 stand up, come on. CNA B told Resident #1, stop acting like you don't know how to walk. Resident #1 continued to sob as CNA B escorted Resident #1 with minimal assist to Resident #1's bed as Resident #1 held the wall for support and pulled up her brief that was falling off. CNA B told Resident #1, stop doing that, you know how to walk. LVN A told Resident #1, no fake crying, no fake crying shame on you. Resident #1 was seated on the edge of her bed at 1:12. CNA B told Resident #1, you don't have one tear coming out of that eye, it's all fake. LVN A said, I know, it's all fake. Resident #1 began to rub her left knee and LVN A said, no, I don't want to hear that, I was standing right there. Resident #1 was crying while sitting on her bed rubbing her left knee from 1:12 to the end of the video. Record review of Resident #1's progress note dated 03/08/2026 at 9:04 PM by LVN A reflected LVN A arrived to shift and noticed Resident #1's red light was flashing so LVN A went to attend to Resident #1's needs. While standing Resident #1 up to transfer Resident #1 had a bowel movement on LVN A's arms and hands and all over Resident #1's wheelchair. After cleaning Resident #1 LVN A and staff placed Resident #1 in bed and put Resident #1's wheelchair in the hallway to clean it later in the evening. Record review of Resident #1's Skin assessment dated [DATE] from Resident #1's EMR reflected front left knee reflected bruising acquired in-house. Record review of Resident #1's progress note dated 03/12/2026 at 4:23 PM reflected ADON evaluated Resident's medication and requested new order for Voltaren gel (a non-prescription, non-steroidal anti-inflammatory topical treatment designed to relieve joint pain) to left knee. Record review of facility obtained statement dated 03/13/2026 by LVN A reflected, I got here and clocked in at 6, I saw [Resident #1's] bathroom call light was on so I walked down the hall and went into her bathroom and asked her what she needed. She was pointing at her brief, 1 asked if she wanted me to put it on for her and she said yes. I put my gloves on and when I went to put the brief on she crapped all over me. It ok I'm a nurse. So I took gloves off, washed hands put [Resident #1's on the toilet went and found aide [CNA A] to get help, she said she's coming after she finished with the resident she was with. 1 went and got started cleaning her up, as I finished [CNA A] showed up and helped. I put the wheelchair in the hall and then [CNA A] called for help cause [Resident #1] was trying to fall/put herself on the floor because she wanted her wheelchair. I didn't do it to be mean, it was dirty and we needed to clean it. I went in and assisted, [CNA A] caught her. I just saw [CNA A] standing there holding her up, we both took an arm and walked her back to her bed. Record review of statement dated 03/13/2026 by CNA B reflected, The initial incident happened-around 6:10 pm, I walked down 400 hall and [LVN A] walked out of [Resident #1's] room. [LVN A] said she had just shit on her, I looked in the bathroom and there was a big mess and [Resident #1] was laughing about it. It's probably about then that you heard me say on the video she needs a psych ward. Interviewee asked if she was going to be terminated after that statement, Administrator informed her she would be. Employee declined to continue participating with the interview and left. Record review of Psychiatric Subsequent assessment dated [DATE] reflected Resident #1 was seen to evaluate her mood/behaviors as requested by the facility social worker/DON/Administrator following alleged incident of abuse incident that occurred 03/08/2026. Resident was known to bang on the door and walls of her room when she needed assistance. Resident was seen in her room sitting on the edge of her bed. Resident #1 was alert with good attention. Resident #1 was smiling and she pointed and rubbed her left knee. During an interview on 03/18/2026 at 10:34 AM, the Administrator said the incident involving Resident #1, LVN A, CNA A, and CNA B occurred on 03/08/2026 and on 03/12/2026 Resident #1's RP told him she had some concerns about Resident #1's care and showed him the videos. The Administrator said he immediately suspended LVN A, CNA A, and CNA B, obtained their statements, terminated their employment, (continued on next page)

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 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	notified the police department, and began his investigation. The Administrator said after reviewing the videos, he felt Resident #1 was verbally abused. During an interview on 03/18/2026 at 11:18 AM with a police detective he said the police would be filing charges on the CNA B who picked up Resident #1 in the bathroom when Resident #1 fell and maybe on LVN A. The detective said the charge would be assault on an elderly and disabled person. During an interview on 03/18/2026 at 12:40 PM, Resident #1's RP said Resident #1 could not walk and Resident #1 had to have a wheelchair. Resident #1's RP said that on 03/08/2026 she received three calls from Resident #1 who was very upset and the RP could not understand what Resident #1 said except that they would not let her have her wheelchair. The RP looked at Resident #1's camera and saw Resident #1's wheelchair was outside of Resident #1's room. The RP said she went to the facility and was told by LVN A that Resident #1 had a bowel movement and Resident #1's Wheelchair was dirty and that was why Resident #1's wheelchair was moved outside of Resident #1's room. The RP said when she saw Resident #1 on 03/08/2026 Resident #1 was traumatized and shaking and extremely upset and the RP thought Resident #1 was upset about the removal of her wheelchair. The RP said she continued to think about the incident because Resident #1 was so upset the RP thought something else might have happened and decided to look at the videos. The RP said it took a few days for her to look at the videos because they were so upsetting and she already had a meeting scheduled with the Administrator on 03/12/2026 and this was when she showed the Administrator the videos and told him what happened. During an interview by phone on 03/18/2026 at 1:41 PM, LVN A said she received training from the facility on abuse, neglect, and exploitation. LVN A said it seemed like every day staff received training in abuse, neglect, and exploitation through facility in-services. LVN A said when she got to work on 03/08/2026, the red light that indicated Resident #1 was in the bathroom and needed assistance was flashing. LVN A went to Resident #1's bathroom. LVN A said she asked Resident #1 what she needed and Resident #1 pointed to the toilet. LVN A said she asked Resident #1 if Resident #1 wanted the toilet or a brief and Resident #1 stood up. LVN A said she went to get a brief and when Resident #1 was standing holding the grab bar and LVN A was putting on Resident #1's brief, Resident #1 pooped everywhere. LVN A said she was shocked when this happened because it was unexpected. LVN A said she was frazzled. LVN A said she knew she needed to get Resident #1 cleaned up and she started to clean the excrement off Resident #1 and the floor with wipes. LVN A said she knew it was horrible and wrong to tell Resident #1 to shut up. LVN A said CNA A came in Resident #1's room and took over cleaning Resident #1 and the bathroom. LVN A said she did not tell Resident #1 not to cry, she did not tell Resident #1 she was disgusting and did not tell Resident #1 that Resident #1 would not think it was funny if Resident #1 was in a psych ward. She said it could have hurt Resident #1's feelings if someone said that to Resident #1. LVN A said she did not think Resident #1 was crying because those things had been said to her. LVN A said Resident #1 had behaviors and cried all the time. Resident #1 said she did know what the CNAs said to Resident #1 because LVN A was busy and did not listen to them. LVN A said Resident #1 could walk when she wanted to. LVN A said she was not aware that Resident #1's care plan said Resident #1 was not able to walk four steps. LVN A said she just knew Resident #1 could walk because she had seen Resident #1 walk. LVN A said she did not know Resident #1 had tremors. LVN A said she was not with Resident #1 when Resident #1 fell. LVN A said if she knew Resident #1 fell, she would have assessed Resident #1 for injuries and done an incident report. LVN A said if someone told Resident #1 that she should go to a psych ward she did not think it would upset Resident #1 because Resident #1 did not know what that would mean. LVN A said telling Resident #1 to shut up was verbally abusive. LVN A said she did not remember what the CNAs told Resident #1. When asked how Resident #1 got to her bed, LVN A said CNA B escorted her to her bed while LVN A went to get more wipes. LVN A said she did not know if Resident #1 was crying because of what someone said to Resident #1 because Resident #1 cried all the time and was part of Resident #1's behaviors. LVN A said Resident #1 suffered no physical abuse at all and she knew Resident #1 could sit and stand on her own. LVN A said she did not know what was in Resident (continued on next page)

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 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1's care plan because she had not read Resident #1's care plan because she had 60 patients. LVN A said she knew Resident #1's ADL abilities because LVN A had known Resident #1 for a long time and saw what Resident #1 could do. LVN A said she did not know if Resident #1 had an intellectual disability or a speech problem. LVN A said she did not know if Resident #1 had behaviors of laughing or crying because of Resident #1's intellectual disability. LVN A just knew that Resident #1 always cried. Attempted interview by phone on 03/18/2026 at 2:08 PM with CNA A. Surveyor attempted to leave a voice mail message, but call ended and a text message was sent. Attempted interview by phone on 03/18/2026 at 2:11 pm, with CNA B. Surveyor left a voice mail message and a text message was sent. During an interview on 03/18/2026 at 2:26 PM, the Administrator said the redness that was indicated on Resident #1's skin assessment dated [DATE] was attributed to the fall Resident #1 had in her bathroom on 03/08/2026. Resident #1's left knee was x-rayed with negative results. The Administrator said this was concretely verbal abuse but said it was not physical abuse because CNA B did not intentionally try to throw Resident #1 to the ground. The Administrator said Resident #1's fall looked like an accident. The Administrator said CNA B and LVN A were not providing Resident #1 was her wheelchair because they wanted to get it cleaned. The Administrator said when CNA B was in Resident #1's bathroom she was assisting Resident #1 to walk to her bed by holding Resident #1's arm. The Administrator said Resident #1 should have been provided with another wheelchair because hers was dirty and there were plenty of wheelchairs available in the therapy area. During an interview on 03/19/2027 at 8:45 PM, the psych NP who conducted the Psychiatric Subsequent assessment dated [DATE] said Resident #1 did not appear to be distressed during the 03/19/2026 assessment. The psych NP said Resident #1 was smiling and calm. The psych NP said she did not discuss the incident with Resident #1. The psych NP said she did not see the videos of the incident that occurred on 03/08/2026 but was told about it by the Administrator but not in any detail. The psych NP said Resident #1 did have a contusion on her knee and Resident #1 was rubbing her knee. The psych NP said after the assessment she was with Resident #1 and Resident #1's RP in the same room. The psych NP said the RP discussed the incident in low tones and the RP was vague about what occurred and gave no details. The psych NP said Resident #1 did not seem to react during this discussion and sat with a pleasant expression. The psych NP said Resident #1 did display any tearfulness, anxiety or fretfulness at all, not even when the RP was talking about it. The psych NP said Resident #1 did not display any psychosocial harm, but Resident #1 was always very happy when she was with her RP. During an interview on 03/19/2027 at 3:01 PM, the DON said she reviewed the videos that involved LVN A, CNA B, and CNA C. The DON said she was appalled and embarrassed to see the videos of abuse because the facility did so much abuse, neglect, and exploitation training. The DON said the videos displayed both emotional and physical abuse. She said the LVN and the CNAs treated the Resident without dignity or respect. The DON said Resident #1 was a fragile woman who they needed to be tender with her. The DON said LVN A and CNA B should have correctly transferred Resident #1 to her bed using a wheelchair. The DON said the facility train the staff at least weekly on abuse, neglect, and exploitation. The DON said she was not concerned about her other staff treating residents and abusing them either mentally or physically. During an interview on 03/19/2027 at 4:17 PM, MA A said she worked on the evening of 03/08/2026 with LVN A, CNA A and CNA B. MA A said she did not hear LVN A, CNA A and CNA B speak inappropriately to any resident and had not previously heard them speak inappropriately to any resident. MA A said she never heard or seen any staff behave abusively or inappropriately to any resident. MA A said if she saw abuse she would first make sure the resident was safe, tell the nurse, and tell the Administrator. MA A said it was never okay to tell a resident to shut up or speak unkindly to a resident. During an interview on 03/19/2027 at 4:24 PM, CNA C said she had not worked directly with LVN A, CNA A, or CNA B but she knew who they were. CNA C said she never heard any staff member tell her that LVN A, CNA A, or CNA B inappropriate or abuse to a resident. She said the Administrator was the abuse and neglect coordinator and she would report abuse immediately. During an interview on 03/19/2027 at 4:31 PM, (continued on next page)

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 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LVN C said she had worked with LVN A, CNA A, and CNA B but she had never heard any of them be inappropriate or abusive to a resident or heard them say anything that was unkind, demeaning, or cursed at a resident. During an interview on 03/19/2026 at 4:38 PM, CNA D said he had worked with LVN A, CNA A, and CNA B and never heard any of them speak inappropriately or be abusive to a resident. During an interview on 03/19/2026 at 4:52 PM, the Administrator said the videos on 03/08/2026 of Resident #1, LVN A, CNA A, and CNA B reflected abuse to Resident #1, both verbally and physically. The Administrator said LVN A and CNA B were clearly making Resident #1 walk when she asked for a wheelchair. The Administrator said he felt that crossed the line because it constituted physical because Resident #1 fell in the process. During an interview on 03/20/2026 at 10:30 AM, the ADON said she was at the facility on 03/08/2026 and LVN A came to her and told her that Resident #1 shit all over her wheelchair. LVN A expressed she was a little upset Resident #1 pooping and LVN A had poop on her hand. The ADON said she told LVN A to get another wheelchair from therapy. The ADON said the facility had loads of wheelchairs. The ADON said she had worked with Resident #1 a lot and knew her pretty well. The ADON said Resident #1 was typically a 1 to 2 person assist and if the wheelchair was by her bed she could transfer herself. The ADON said that Resident #1 cried and became upset when she could not express herself. The ADON said Resident #1 was a high fall risk. The ADON said if the wheelchair was too far from her bed Resident #1 would cry because she could not get out of bed. The ADON said they could easily have gotten Resident #1 another wheelchair. The ADON said she had not seen Resident #1 walk in a long time. The ADON said it was her expectation that all staff used the Kardex (a centralized quick-reference tool often part of the electronic health record that summarized a resident's daily care needs including Activities of Daily Living). The ADON said nurses do not really look at resident care plans, but it was her expectation for nurses and CNAs to look at the Kardex because it was a mini care plan. The ADON said it was her expectation that staff treated residents with respect and dignity. The ADON said she had worked at the facility for 6 and had not seen or heard any staff treat residents abusively. The ADON said if you said something mean to Resident #1, she would cry. The ADON said if someone told Resident #1, she was nasty, she would cry. The ADON said Resident #1 absolutely was cognitive enough to know when someone was being mean to her and it would make her cry. During an interview on 03/20/2026 at 11:03 AM, CNA E said she worked a lot with Resident #1 and knew her pretty well. CNA E said she would never ask Resident #1 to walk from the bathroom to the bedroom because it was not safe. CNA E said she had never known Resident #1 to walk. CNA E said Resident #1 would cry if someone said something mean to her. CNA E said she never worked with LVN A, CNA A, or CNA B. CNA E said she had been trained 1, 000 on abuse, neglect, and exploitation. CNA E said an example of verbal abuse would be calling residents names and telling them they were nasty. She said they had plenty of extra wheelchairs available for use. CN A E said the Administrator was abuse and neglect coordinator. She said as a CNA she had access to the Kardex and she looked at it all the time. She said the Kardex detailed the transfer and ADL status of a resident. During a video observation of a forensic interview on 03/25/2026 at 10:03 AM of Resident #1 coordinated by a police detective, Resident #1 was asked by interviewer at the Advocacy Center if someone pushed her and she nodded yes. When she was asked who her pushed her it was unintelligible. Resident #1 began to cry when asked if she got hit. Resident #1 began to cry when asked if she was left alone in the bathroom. Resident #1 began to cry when asked if she was hit or pushed. Observed Resident #1 removing a cell phone from her purse. When Resident #1 was asked if she wanted to call her RP and said yes, interview ended. Record review on 03/18/2026 of facility HHS Provider Investigative Report dated 03/12/2026 reflected description of allegation - Resident RP showed video footage of Resident #1's room on the evening of 03/08/2026 of three staff members speaking derogatorily to Resident #1 while caring for her and not allowing her to use a wheelchair when transferring from bathroom to bed. Investigation report included facility investigation including resident profile and description of the incident. After first learning of the incident and being informed on 03/12/2026 by Resident #1's RP, the facility took the following action (continued on next page)

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 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on 03/12/2026: Initiated investigationMD notified Behavioral Services notified and referred to visit residentPerpe[TRUNCATED]