

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/30/2026
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews, observations, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 48 of 90 days reviewed for RN coverage. The facility failed to ensure there was a RN scheduled on duty for 48 days (11/03/2025, 11/04/2025, 11/05/2025, 11/07/2025, 11/09/2025, 11/10/2025, 11/11/2025, 11/12/2025, 11/13/2025, 11/17/2025, 11/18/2025, 11/19/2025, 11/21/2025, 11/24/2025, 11/25/2025, 11/26/2025, 12/01/2025, 12/03/2025, 12/04/2025, 12/05/2025, 12/08/2025, 12/09/2025, 12/11/2025, 12/12/2025, 12/15/2025, 12/16/2025, 12/18/2025, 12/19/2025, 01/01/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/12/2026, 01/13/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/20/2026, 01/21/2026, 01/22/2026, 01/23/2026, 01/26/2026, 01/27/2026, 01/28/2026, 01/29/2026, and 01/30/2026) and failed to ensure the DON was not acting as the charge nurse when the facility had an average daily occupancy of more than 60 residents. This failure could place residents at risk of missed nursing assessments, interventions, care, and treatment. Findings included: Record review of the daily staffing for 11/03/2025 through 10/01/2026, reflected zero hours worked by an RN, on the following days: 11/03/2025, 11/04/2025, 11/05/2025, 11/07/2025, 11/09/2025, 11/10/2025, 11/11/2025, 11/12/2025, 11/13/2025, 11/17/2025, 11/18/2025, 11/19/2025, 11/21/2025, 11/24/2025, 11/25/2025, 11/26/2025, 12/01/2025, 12/03/2025, 12/04/2025, 12/05/2025, 12/08/2025, 12/09/2025, 12/11/2025, 12/12/2025, 12/15/2025, 12/16/2025, 12/18/2025, 12/19/2025, 01/01/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/12/2026, 01/13/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/20/2026, 01/21/2026, 01/22/2026, 01/23/2026, 01/26/2026, 01/27/2026, 01/28/2026, 01/29/2026, and 01/30/2026. Record Review on 1/30/2026 of the Facility Monthly Schedule LVN/RN reflected DON as the only RN on staff from 11/20/2025 to 1/30/2026. During an observation on 1/30/2026 at 12:00 p.m., a facility staffing schedule posted at the front entrance displaying the 12-hour shifts for nursing staff revealed one RN listed on the schedule for 01/30/2026. During an interview on 01/30/2026 at 12:14 p.m., the ADM stated he never had a census under 60 and the facility did not have a policy in place at this time related to Nurse scheduling or RN coverage. During an interview on 01/30/2026 at 1:55 p.m., the DON stated she was available 24-7 by phone, and 9:00 a.m.-7:00 p.m. in the building Monday - Friday. The DON stated she was only in the building during the week, and other RNs filled in on the weekend. She stated it was important to have an RN eight hours a day to make sure interventions were performed by an RN. During an interview on 01/30/2026 at 2:01 p.m., LVN E stated an RN should be available Monday - Friday on staff and if an RN was not available, they called someone in. He did not recall a time when there was not RN coverage. LVN E stated if an RN was unavailable the Regional RN filled in. He stated it was important to have an RN on duty in case problems arose, such as a resident needing to have a PICC line removed, which could only be done by an RN. During an interview on 01/30/2026 at 2:40 p.m., LVN F stated an RN should always be on duty. LVN F stated she did the scheduling for the nurses. She stated she was new to this position and still being trained, but if an RN was not on duty there were things out of the scope of the LVN, so this would put residents at risk if an RN were not available.		

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
FORM CMS-2567 (02/99) Event ID: Facility ID: 676222 If continuation sheet Page 1 of 5		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 6 residents (Residents #10, #18, and Resident #56) reviewed for care plans. The facility failed to develop comprehensive person-centered care plans for Residents #10, #18, and #56 by not care planning for the residents' refusals to take showers. This failure could place residents at risk of not having their needs met to attain their highest practicable well-being. Findings included: Record review of Resident #10's face sheet, dated 01/30/2026, reflected an [AGE] year-old female, admitted [DATE]. Her diagnoses included pleural effusion (excess buildup of fluid in the pleural space, often causing chest pain and shortness of breath), type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema (chronic, often asymptomatic early-stage eye complication requiring blood sugar, blood pressure, and cholesterol management to prevent vision loss), and acute respiratory failure with hypoxia (the lungs fail to provide enough oxygen to the body's tissues). Record review of Resident #10's care plan, dated 12/16/2025, reflected Resident #10 had an ADL self-care performance deficit related to advanced age with intervention bathing/showering Resident #10 required maximum assist by one staff with showering during scheduled shower times and as necessary. Resident #10's care plans had no care plan for bathing preferences or refusals to take showers or bath. Record review of Resident #10's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C, Cognitive Patterns, dated 12/08/2025, revealed a BIMS score of 15, indicating no cognitive impairment. Section F, Preferences for Customary Routine and Activities, reflected an interview for daily and activity preferences was completed by resident or family/signific other for receiving tub bath, receiving shower, receiving bed bath. Record review of facility shower sheet, dated 01/21/2026, for Resident #10 reflected that she refused a shower. Record review of facility shower sheet, dated 01/28/2026, for Resident #10 reflected that she refused a shower. Record review of Resident #10's progress notes reflected no documentation of Resident #10 refusing a shower. During an interview on 01/29/2025 at 2:05 p.m., Resident #10 said the staff were nice and she felt safe at the facility. She did not state she had a concern about showers. Record review of Resident #18's face sheet, dated 01/30/2026, reflected a [AGE] year-old female admitted [DATE] and re-admitted [DATE]. Her diagnoses included vascular dementia (caused by an impaired supply of blood to the brain), type 2 diabetes mellitus with diabetic chronic kidney disease (high blood sugar has damaged the kidneys' filtering units (nephrons) over time, reducing their ability to remove waste) and hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side (weakness or paralysis on the right side of the body resulting from non-traumatic brain damage). Record review of Resident #18's care plan, dated 12/16/2025, reflected Resident #18 had an ADL self-care performance deficit related to dementia (a general term for a progressive decline in memory, thinking, and behavior, severe enough to interfere with daily life) dated 04/19/2023 with intervention dated 12/08/2025 as evidenced by Resident #18 required extensive assist by staff with showering three times per week and as necessary. Resident #18's care plans had no care plan for bathing preferences or refusals to take showers or bath. Record review of Resident #18's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C, Cognitive Patterns, dated 11/21/2025, reflected a BIMS score of 8, indicating moderate cognitive impairment. Section GG, Functional Abilities, dated 11/21/2025, reflected shower/bathe self: the ability to bathe self, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including washing, rinsing, and drying self (excluded washing of back and hair). Does not include transferring in/out of tub/shower - partial/moderate assistance - helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Record review of facility shower sheet, dated 11/04/2025, for Resident #18 reflected that she refused a shower. Record review of facility shower sheet, dated 11/24/2025, for Resident #18 reflected that she refused a shower. Record review of facility shower sheet, dated 01/29/2026, for Resident #18 reflected that she refused a shower. Record review of Resident #18's progress notes reflected no documentation of Resident #18 refusing a shower. During an interview on 01/30/26 at 10:34 a.m., Resident #18's RP said Resident #18 was not inter-viewable. Resident #18's RP said she was concerned that the staff at the facility did not bathe Resident #18. Resident #18's RP said sometimes when visited Resident #18, Resident #18 smelled bad. Record review of Resident #56's face sheet, dated 01/30/2026, reflected a [AGE] year-old male, admitted [DATE] and re-admitted [DATE]. His diagnoses included dementia, presence of automatic (implantable) cardiac defibrillator (device implanted to monitor heart rhythms and deliver life-saving shocks), and alcohol abuse. Record review of Resident #56's care plan, dated 11/10/2025, reflected Resident #56 had an ADL self-care performance deficit related to advanced age, muscle wasting and weakness, dementia, propane exposure, malnutrition, cardiac deliberator (a battery-powered device that monitors heart rhythm), adult failure to thrive, alcohol abuse, stimulant use, CHF with bathing/showering interventions, dated 10/11/2025, to avoid scrubbing and pat dry sensitive skin, check nail cleanliness, length and trim as needed on bath day and prn and report any changes to the nurse and provide sponge bath when a full bath or shower cannot be tolerated. Resident #56's care plans had no care plan for bathing preferences or refusals to take showers or bath. Record review of Resident #56's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment, Section C - Cognitive Patterns, dated 11/24/2025 reflected a BIMS score of 15, indicating no cognitive impairment. Section GG, Functional Abilities, was not completed. Record review of facility shower sheet, dated 12/24/2025, for Resident #56 reflected he refused a shower. Record review of facility shower sheet, dated 12/26/2025, for Resident #56 reflected he refused a shower. Record review of facility shower sheet, dated 12/29/2025, for Resident #56 reflected he refused a shower. Record review of facility shower sheet, dated 12/31/2025, for Resident #56 reflected he refused a shower. Record review of facility shower sheet, dated 01/02/2026, for Resident #56 reflected he refused a shower. Record review of facility shower sheet, dated 01/09/2026, for Resident #56 reflected he refused a shower. Record review of facility shower sheet, dated 01/14/2026, for Resident #56 reflected he refused a shower. Record review of facility shower sheet, dated 01/16/2026, for Resident #56 reflected he refused a shower. Record review of facility shower sheet, dated 01/28/2026, for Resident #56 reflected he refused a shower. Record review of facility shower sheets Form, undated, reflected, ALL showers must be completed per schedule. If a resident refuses shower, nail care or facial hair to be shaved you must NOTIFY Charge Nurse and have them sign that they were notified. All showers are to be documented in POC Charting (real-time documentation of patient care directly at the bedside or at the time of service). Record review of Resident #10's progress notes reflected no documentation of Resident #10 refusing a shower. Record review of Resident #18's progress notes reflected no documentation of Resident #18 refusing a shower. Record review of Resident #56's progress notes reflected no documentation of Resident #18 refusing a shower. During an interview on 01/29/2025 at 2:05 p.m., Resident #10 said the staff were nice and she felt safe at the facility. She did not state she had a concern about showers. During an interview on 01/30/26 at 10:34 a.m., Resident #18's family member said Resident #18 was not interviewable. Resident #18's family member said she was concerned that the staff at the facility did not bathe Resident #18. Resident #18's family member said sometimes when they visited Resident #18, Resident #18 smelled bad. During an interview on 01/09/2026 at 9:56 a.m. Resident #56 said he was doing well and had no concerns or issues. During an interview on 01/30/2026 at 10:59 a.m., CNA A said she was the shower aide for Resident #18. She (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said that the facility used shower sheets to record resident showers. She said that residents could begin to smell bad if they did not have a shower. She said that every time Resident #18 refused a shower, she marked Resident #18's refusal on her shower sheet. She said when a resident refused a shower, she made a few attempts to get them to take a shower and if the resident still declined a shower, she told the nurse, and the nurse tried to get the resident to take a shower. CNA A said ff the resident still did not take a shower, she marked refusal on the shower sheet. She said she documented on shower sheets that Resident #18 refused showers, but some of her shower sheets for her hallway, which included both Resident #10 and Resident #18, were missing. CNA A said Resident #18 refused to take a shower at least once a week. During an interview on 01/30/26 at 11:33 a.m., CNA B stated she was a shower aide and worked at the facility for four years. She said there was a shower sheet used to indicate if the resident took a shower or refused a shower. She said if a resident refused a shower, she would ask the resident a few more times to take a shower and, if the resident still declined, she told the nurse about the resident's shower refusal. During an interview on 01/30/26 at 12:05 p.m., LVN G stated she provided care to Resident #18, and Resident #18 refused showers. She said when a resident refused a shower, she documented the refusal in progress notes in POC (a cloud based electronic health record and software platform designed for the senior long-term care). LVN G said a care plan was the plan of care for what care a resident would receive from the facility. She said that the care plan included the goals for a resident to meet and maintain. She said if a resident had a history of refusing showers, staff should include this in care plan. She said the MDS coordinator did the facility care planning. She said the Charge Nurse who initially admitted the resident did the initial baseline care plan and then the MDS Coordinator did the rest of the resident care planning. She said she as a nurse did not have a lot to do with resident care plans. She said if a resident refused showers, she would chart a progress note and tell the DON. She said a possible negative effect of a resident not getting a shower would be body odor, the resident's peri area would be more susceptible to bacteria and the resident's skin would be more susceptible to breakdown because of a buildup of bacteria. During an interview on 01/30/26 at 12:13 p.m. LVN C said both Resident #10 and Resident #18 refused to take showers. She said that Resident #10 refused to take her showers about two times a week. She said Resident #10 would hold onto the arms of her wheelchair to indicate she did not want to take a shower. She said Resident #18 refused to take a shower because she said it was too cold. She said she did not document in POC when residents refused their showers. LVN C said she would let the DON know about resident shower refusals, but she did not recall if she ever told the DON about Resident #10 refusing her showers. LVN C said a care plan contained the goals and interventions that were planned for the residents. She said it would be good to care plan resident shower refusals because if shower refusals continued, it indicated the resident's preference. LVN C said the MDS Coordinator was responsible for facility care plans. She said nurses participated in care plan meetings and gave information about the residents but did not update the care plan. She said she did not know who was responsible for updating resident care plans. She said if a resident did not take a shower, bacteria could build up, and it was a hygiene issue. During an interview on 01/30/26 at 12:45 p.m., the RCMSS stated she was the current MDS Coordinator at the facility. She said a care plan was everything involved with the care of the residents. She said she looked at orders and POC documentation and communicated with the floor staff, nurses and CNAs, to create a care plan. She said if a resident had a history of refusing showers, the refusal should be indicated in the care plan. She said she looked at CNA documentation, including shower sheets, to get information for resident care plans. She said it was her expectation that staff would communicate with her about resident refusals. The RCMSS said the possible negative effect of not documenting shower refusals would be that the resident could have skin issues and the facility needed to get ahead of the skin issues before it became a problem for the residents. During an interview on 01/30/26 at 1:22 p.m., the DON stated a care plan was the format of how the staff were going to care for the residents. She said the care plan was the book of life for residents and wanted (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be informed about residents refusing showers. She said the CNA should tell the nurse about shower refusals and the nurse should tell the DON or the ADON and then the refusal was care planned. The DON said the possible negative effect of not care planning shower refusals was that staff were not going to know what was going on with the residents and staff would not know the residents' habits and be able to plan for them. Record review of policy title Facility Plan Revisions Upon Status Change, dated 10/24/2022, reflected the purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs. 3. The MDS Coordinator will determine whether a Significant Change in Status Assessment is warranted. If so, the assessment will be completed according to established procedures.		