

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Spjst Rest Home 1		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 Old Granger Road Taylor, TX 76574	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to develop and implement a person-centered comprehensive care plan to meet the preferences and goals of each resident and address the resident's medical, physical, mental and psychosocial needs for one (Resident #1) of five residents reviewed for care plan in that: The facility failed to update Resident #1's care plan after an X-ray (a form of electromagnetic radiation used in medicine to create images of the inside of the body for diagnostic purposes) result dated 07/01/2026 reflected a nondisplaced (a fracture where the bone pieces stay properly aligned) acute appearing fracture noted of the right distal tibia (the lower end of the shinbone (tibia) that connects to the ankle joint) This deficient practice placed residents at risk for not getting right interventions, risk for harm and hospitalization. Findings included: Review of Resident #1's face sheet printed 07/14/2026 reflected a [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE] with the following dx: Alzheimer's disease with late onset (the most common form of dementia, developing in individuals aged 65 and older. It typically presents with progressive short-term memory loss, language difficulties, and impaired judgment.), Age-related physical debility, Pain in right lower leg. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 00, indicating the Resident #1 was unable to participate. It also indicated both short and long-term memory problems. Review of Resident 1's care plan edited 06/09/2026 reflected Resident #1 was at risk for falls due to weakness and impaired cognition, had complaints of pain/discomfort and is at risk for injury from decrease in ADLs fragile skin and a potential for skin tears and bruising and Resident #1 had impaired decision-making related to Alzheimer. Resident #1's care plan did not address Resident #1 having a fracture of her right tibia. Review of Resident #1's progress notes dated 07/01/2026 at 10:39 am written by LVN A reflected: 8/9 RLE discoloration, resident is up in wc this shift, continues to express pain to RLE when moved. Resident will not keep leg elevated on footrest while in wc. Residents have PRN acetaminophen 325 mg x 2 order for pain medication, will administer to resident. Resident has received an order from hospice nurse [name] for x ray to RLE, at RP request. [Company name] Radiology has been faxed with orders, phone call to verify received, no ETA given. Review of Resident #1's X-ray completed on 07/01/2026 reflected: RIGHT ANKLE. AND TIBIA/FIBULA (the calf bone), 3 VIEWS-- There is a nondisplaced fracture noted of the distal tibia. Talar dome (upper surface of the ankle and ankle mortise(a joint that connect 2 pieces) appear normal. The bony mineralization is unremarkable (within normal limit). There is mild soft tissue swelling noted. Impression:Nondisplaced acute appearing fracture noted of the distal tibia. Review of Resident #1's Progress notes dated 07/01/2026 at 09:55 pm written by LVN B reflected: At 3:00 pm in bed resting [Company name] radiology here to do X-ray R leg, when results received DON aware of findings, 7:20 pm new order from [Hospice nurse] RN (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676290	Facility ID: 676290 If continuation sheet Page 1 of 2

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place boot on R foot with fracture, elevate foot, leave in bed next 2-3 days turn and reposition as needed, 9:00 pm resting quietly will monitor, RLE with dark purple bruising and swelling note is on eliquis 2.5 mg (blood thinner medication) oral will continue to monitor. During an interview on 07/14/2026 at 2:27 pm the DON stated the facility was aware of Resident #1's right tibia fracture. The DON stated the X-ray was completed on 07/01/2026 on Resident #1's right tibia and was positive for fracture. The DON stated Resident #1 went out on pass with her family on 06/27/2026 and by 06/29/2026 the facility noticed discoloration at right leg and was monitoring due to Resident #1 being on a blood thinner medication. The DON stated Resident #1's right tibia fracture should have been care planned to enable staff to know what interventions to provide for Resident #1. The DON stated she, the ADON and the MDS Nurse were responsible to update Resident #1's care plan to reflect right tibia fracture with interventions. The DON stated she was supposed to ensure all care plans were updated. During an interview on 07/14/2026 at 3:06 pm the ADON stated she was aware of her Resident #1's fracture. The ADON stated she and the DON were responsible for updating care plans as needed when there was a change or some incident or the resident was on an ABT. The ADON stated she and the DON would update the care plan for the fracture to indicate increased care, and that Resident #1 was wearing a boot to her right leg. The ADON stated she did not update Resident #1's care plan to reflect the fracture, she just did not get to it. During an interview on 07/14/2026 at 3:51 pm the MDS Nurse stated she was responsible for completing and updating comprehensive care plan. The MDS Nurse stated care plans were updated quarterly and for significant changes like falls, antibiotics, fracture, etc. (the rest). The MDS Nurse stated she only worked part-time and the DON and ADON were responsible for updating care plans when there were changes. The MDS Nurse stated Resident #1 care plan should have been updated after the fracture to reflect the boot, pain management, level of assist and transfer needed. The MDS Nurse stated it was supposed to be updated so the staff can know the interventions that were in place. The MDS Nurse stated she did not update Resident #1's care plan. Review of facility's policy revised December 2016 titled Care Plans, Comprehensive Person-Center reflected: Policy Statement: A comprehensive, person-center care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representatives, develops and implements comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Assessment of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The Interdisciplinary Team must review and update the care plan:--when there has been a significant change in the residents' condition.--when the desired outcome is not met.--when the resident has been readmitted to the facility from a hospital stay; and--at least quarterly, in conjunction with the required quarterly MDS assessment.		