

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: 676290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen.1. The facility failed to properly thaw raw chicken in the sink, not under running water, in its kitchen on 01/13/2026.2. The facility failed to properly store, label, and date all food items located in the facility refrigerators, freezers and in the dry food pantry area on 01/13/2026 and 01/14/2026. 3. The facility failed to discard outdated food items located in the refrigerators on 01/13/2026 and 01/14/2026. 4. The facility failed to properly seal food product bags in the dry storage area to prevent exposure to air on 01/13/2026 and 01/14/2026. 5. The facility failed to properly store, label, and date all food items located in the satellite refrigerators on halls 100/200,400, and 500/600 on 01/13/2026.These failures could place residents who received meals from the kitchen at risk of foodborne illnesses.Observation during the initial tour of the kitchen on 01/13/2026 beginning at 9:02 AM revealed the following:Refrigerator 1:6 bowls of potato salad, no name, no date, no discard/use by date5 chef salads, no name, no date, no discard/use by date 2 plates of cheese sandwiches, no name, no date, no discard/use by date1 small bowl of pickles and tomatoes, no name, no date, no discard/use by date1 small bowl of mixed berries, no name, no date, no discard/use by date 1 large opened bag of chocolate chips, not sealed with receive date of 10/23/2025, no open or discard date.12 cartons of expired Heavy Whipping Cream, expired 11/14/2025.1 storage bag with unknown prepared product that resembles icing, no name, no date, no discard/use by date Kitchen area: 1large bin of sugar, no name, no date, no discard/use by date 1 large bin of flour, no name, no date, no discard/use by date 1 large bin of unknown product that resemble white corn meal, no name, no date, no discard/use by date 1 storage bag of raw chicken sitting in container in sink, not under running water. Dry Food Pantry area:10 packs of hot dog buns, no received dates, no discard/use by dates1 hamburger buns, no open or discard date.1 opened package of pasta dated 11/10/2025, no discard/use by dates2 opened package of macaroni, no open, discard/use by date1 opened package of bowtie pasta, not sealed open to air, no open, discard/use by date1opened bag of cake mixes, not sealed open to air, no open, discard/use by date1 opened bag of baking soda labeled 6/523 and another open bag of baking soda labeled 11/5/231 large container of Asian sauce, open date 11/24/25, no discard/use by date1 large container of corn meal, marked 9/23/25 no discard/use by dateWalk in Freezer:3 packages of unlabeled meat that resembles turkey, no name label, or receive date1 box of open pizza crust, open to air with receive date of 10/13/251 storage bag of open popcorn chicken, open date, no discard/use by date 1 open bag of open fish, no open date, no discard/use by dateWalk in Refrigerator :Container of opened peaches, not labeled, no open date, no discard/use by date5 large gallon containers of opened salad dressings (open dates ranging from 10/6/25 -12/15/25), no discard/use by dates1 prepared pan of sliced tomatoes with only date of 1/8/26 , no discard/use by date1 open bags of lettuce, with only date of 1/5/26 on it, no discard/use by dateObservation and interview conducted 01/13/2026 at 9:36 AM. Observed raw chicken still sitting in the container in the sink. The [NAME] was asked, is that the way they thaw their meat? He responded, Normally, sometimes water runs over it, but we leave it in the sink.Satellite Refrigerator (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for Hall 500/600: 1 container of apple juice, prep date of 1/9/26, no discard date1 container of orange juice, prep date of 1//26, no discard date 1 container of apple juice, prep date of 1/13/26, no discard dateSatellite Refrigerator for Hall 100/200: 1 container of tea , prep date of 1/9/26, no discard date1 container of orange juice, prep date of 1/9/26, no discard date 1 container of apple juice , prep date of 1/13/26, no discard date 1 open gallon of milk, with best buy date of 1/12/26, no discard date Satellite Refrigerator for Hall 400 1 container of fruit punch , prep date of 1/12/26, no discard date 2 bowls of potato salad no name, no prepared date, no discard date 1 plate of cheese sandwich, no name, no prepared date, no discard date 1 bowl of peaches with cottage cheese, no name, no prep date, no discard date Observation during the follow up tour of the kitchen on 01/14/2026 beginning at 11:00 AM, revealed the following:Refrigerator 1:1 large, opened bag of chocolate chips, not sealed with receive date of 10/23/2025, no open or discard date.12 cartons of expired Heavy Whipping Cream, expired 11/14/2025.1 storage bag with unknown prepared product that resembles icing, no name, no date, no discard/use by date Kitchen area: 1large bin of sugar, no name, no date, no discard/use by date 1 large bin of flour, no name, no date, no discard/use by date 1 large bin of unknown product that resemble white corn meal, no name, no date, no discard/use by date 10 packs of hot dog buns , no receive dates, no discard/use by dates1 hamburger buns, no open or discard date.1 opened package of pasta dated 11/10/2025, no discard/use by dates2 opened package of macaroni, no open, discard/use by date1 opened package of bowtie pasta, not sealed open to air, no open, discard/use by date1opened bag of cake mixes, not sealed open to air, no open, discard/use by date1 opened bag of baking soda labeled 6/5/23 and another open bag of baking soda labeled 11/5/231 large container of Asian sauce, open date 11/24/25, no discard/use by date1 large container of corn meal, marked 9/23/25 no discard/use by dateInterview conducted with the [NAME] on 01/15/2026, at 4:16 PM. The [NAME] stated he has worked as a cook with the facility since April 1st, 2025. The [NAME] stated he has been trained on the food handling policy. Surveyor asked the [NAME] did he think the chicken observed in the kitchen sink on 1/13/2026 was thawing properly. The Cooks stated he found out one of the staff placed the chicken in the sink, he stated it was not for the residents, it was for staff. The [NAME] stated he does not believe staff can prepare food from home in the kitchen. The [NAME] stated he normally does not thaw food on his shift as it is thawed prior to his shift. In regard to labeling, dating, and discarding of food items, the [NAME] stated the food is labeled with the date received and opened. He was asked about the discard date, the [NAME] stated it depends on the item. He stated juices and ice teas have 3 days of shelf life, sandwiches 2 days of shelf life. He stated he has not seen cooked food sit for longer than a week. The [NAME] stated he does not know the facility discard policy or if he has seen it or not. The [NAME] stated they dispose of expired foods in the mornings. He stated the dietary aide does most of the discarding of expired foods, but it is everyone's responsibility. He stated that if residents eat outdated food, they can possibly get food poisoning, salmonella, and become sick.Interview conducted with DM A on 01/15/2026, at 4:40 PM. DM A stated she has worked at the facility for 2 years and she became the dietary manager in July 2025. DM A stated that she pairs new dietary staff with an experienced staff member to review kitchen tasks. DM A explained that when thawing food, staff remove items from the freezer and place them under running cold water. She stated that she saw the chicken thawing on Tuesday while surveyors were present and turned the water back on. DM A reported that food items are labeled with the date received, and once they are opened, they are labeled with the open date but not always a discard date. When asked how staff know when to discard items, DM A stated that items are discarded after seven days. She stated that juices have a five-day shelf life, and teas are discarded after 24 hours. She stated that cooked food items are good for five days. DM A stated that dietary staff conduct weekly inventory checks and monitor for expired items. She stated that dietary staff are responsible for checking satellite kitchens daily. Surveyor showed her pictures of expired and leftover food items that remained in the refrigerators that were not discarded, Dietary Manager stated the items should have been discarded, and she would throw them out. DM A stated that (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	potential harm to residents from consuming expired food includes upset stomach, vomiting, and possible hospitalization. Interview conducted 01/15/2025 at 6:32 PM, the ADM stated he has been with the facility since July 1, 2025. ADM stated raw chicken should not be sitting out, whether it is for the residents or the staff. He stated he could not fully explain the labeling and dating policy, he stated he knows the items should be labeled with the date in and date opened. He stated all items should have some type of a label and date. ADM stated he expects his dietary staff to follow the policy. He stated a resident could become ill if they ate expired food items. Interview conducted with DM B on 01/16/2026, at 10:11 AM. DM B stated that food labeling should include the date received, date opened, and expiration date. DM B stated that she tells the staff tons of times, this procedure. She stated that staff turnover is high, and employees often leave. DM B stated that food is discarded after three days, five days, or seven days depending on the item, and that the facility does not keep a large amount of cooked food. She stated that potential harm to residents from consuming expired food includes food poisoning, which is especially dangerous for elderly residents. Interview conducted with the Dietary Aide on 01/15/2026 at 10:24 AM. The Dietary Aide stated he has been employed at the facility for seven years. He stated he was initially trained by a previous Dietary Manager, many years ago. The Dietary Aide stated all staff are responsible for labeling and dating food items. He reported staff are expected to write the date received, the date opened, and the discard date, which is three days for food that is open and 7 days for juices. The Dietary Aide stated that the potential harm that could occur if food is not discarded properly is that a resident could become very sick with diarrhea or vomiting. Record review of the facility's policy dated July 2014, named Preventing Foodborne Illness-Food Handling revealed: Policy Statement Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. 1. This facility recognizes that the critical factors implicated in foodborne illness are: a. Poor personal hygiene of food service employees; b. Inadequate cooking and improper holding temperatures; c. Contaminated equipment; and d. Unsafe food sources. 2. With these factors as the primary focus of preventative measures, this facility strives to minimize the risk of foodborne illness to our residents. 3. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. Record review facility's policy dated July 2014, named Food receiving and Storage revealed: Policy Statement Foods shall be received and stored in a manner that complies with safe food handling practices. 7. Dry foods that are stored in bins will either be removed from their original packaging, placed in a clean and dry bin, labeled and dated, or left in its original packaging with the proper date on the packaging. 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). 9. Refrigerated foods must be stored below 41°F unless otherwise specified by law. 10. Refrigerated foods will be stored in such a way that promotes adequate air circulation around food storage containers. Refrigerators/walk-ins will not be overcrowded. 11. The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing. 12. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements. 13. Uncooked and raw animal products, including raw eggs) and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods. 14. Food items and snacks kept on the nursing units must be maintained as indicated below: All food items to be kept below 41°F All foods belonging to residents must be labeled with the resident's name, the item and the use by date. Beverages must be dated when opened and discarded after twenty-four (24) hours.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 9 of 20 residents (Resident #3, Resident #19, Resident #27, Resident #34, Resident #38, Resident #43, Resident #63, Resident #64, and Resident #88) reviewed for misappropriation. The facility failed to prevent the misappropriation of Residents #3, 34, 38, 64, and 88's tramadol (a schedule IV controlled opioid medication used to treat moderate to severe pain), Residents #19, 27, and 63's lorazepam (a schedule IV controlled benzodiazepine medication used to treat anxiety), Residents #27 and #63's hydrocodone-acetaminophen (a schedule II controlled opioid medication used to treat severe pain), Resident # 43's acetaminophen-codeine (a schedule III opioid medication used to treat moderate to severe pain), and Resident #88's oxycodone (a schedule II opioid medication used to treat moderate to severe pain) taken from 01/03/2026 through 01/15/2026. This failure placed residents at risk for not receiving prescribed medications for pain and anxiety relief. Findings included: 1. Review of Resident #3's face sheet, dated 01/15/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included pressure ulcer of sacral region (opening in skin due to pressure to lower back/buttock area), unspecified pain, and retention of urine. Review of Resident #3's Quarterly MDS, dated [DATE], reflected a BIMS score of 01 which indicated severe cognitive impairment. Review of Resident #3's undated order summary reflected tramadol - Schedule IV tablet; 50 mg; amt: 1 tab; oral Every 6 Hours - PRN with a start date of 08/20/2024. Review of Resident #3's care plan, dated 01/02/2026, reflected I have chronic pain with turning positioning and treatment to my wound. With approaches that included Administer Tramadol as ordered Apply Lidocaine patch as ordered. Turn reposition to keep comfortable. 2. Review of Resident #64's face sheet, dated 01/15/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and most recent readmission on [DATE] with diagnoses that included pressure ulcer of the left ankle, chronic pain syndrome (a complex condition characterized by persistent pain lasting longer than three months), and primary osteoarthritis (the cartilage between the bones wears away causing pain) unspecified site. Review of Resident #64's Quarterly MDS, dated [DATE], reflected a BIMS score of 08 which indicated moderate cognitive impairment. Review of Resident #64's undated order summary reflected tramadol - Schedule IV tablet; 50 mg; amt: 1 tablet; oral Three Times A Day 08:30 AM, 12:30 PM, 08:30 PM with a start date of 06/06/2024. Review of Resident #64's care plan, dated 12/12/2024 and last revised 12/09/2025, reflected I have complains of increased pain/discomfort and is a risk for injury from decrease in ADLs. [sic] With approaches that included Administer medication as ordered per the physician. 3. Review of Resident #63's face sheet, dated 01/15/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included unspecified pain, generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues), and osteoarthritis (the cartilage between the bones wears away causing pain) of the left shoulder and left knee. Review of Resident #63's Comprehensive MDS, dated [DATE], reflected a BIMS score of 13 which indicated no cognitive impairment. Review of Resident #63's undated order summary reflected hydrocodone-acetaminophen - Schedule II tablet; 5-325 mg; amt: 1 tab; oral Three Times A Day 09:30 AM, 01:30 PM, 05:30 PM with a start date of 07/18/2025 and lorazepam - Schedule IV tablet; 1 mg; amt: 1 tablet; oral Every 6 Hours 06:00 AM, 12:00 PM, 06:00 PM, 12:00 AM with a start date of 03/21/2025. Review of Resident #63's care plan, dated 08/01/2024 and last revised 12/23/2025, reflected I am taking anti-anxiety medication. And I have complains of increased pain/discomfort and is a risk for injury from decrease in ADLs. I have pain from osteoarthritis to the left shoulder and of the left knee. This causes me debility. [sic] With approaches that include Administer medication as ordered per the physician. 4. Review of Resident #19's face sheet, dated 01/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included unspecified pain, restlessness and (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	agitation. Review of Resident #19's Quarterly MDS, dated [DATE], reflected a BIMS score of 11, which indicated moderate cognitive impairment. Review of Resident #19's undated order summary reflected lorazepam - Schedule IV tablet; 1 mg; amt: 1 tab; oral At Bedtime 08:30 PM with a start date of 09/15/2025 and lorazepam - Schedule IV tablet; 1 mg; amt: 1 tab; oral Special Instructions: x 180 days Every 4 Hours - PRN with a start date of 09/15/2025. Review of Resident #19's care plan, dated 09/15/2025 and last revised 01/05/2026, reflected I am taking anti-anxiety medication r/t y[sic?] restlessness and forgetfulness. 5. Review of Resident #27's face sheet, dated 01/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included unspecified pain, anxiety disorder (a mental health condition that causes intense and excessive worry and fear), and cognitive communication deficit (problem with communication caused by cognition rather than a language or speech deficit). Review of Resident #27's Comprehensive MDS, dated [DATE], reflected she had a memory problem with Short-term and Long-term Memory. Review of Resident #27's undated order summary reflected Ativan (lorazepam) - Schedule IV tablet; 0.5 mg; amt: 1 tab; oral Special Instructions: Dose 0.5mg, give 1 tab for anxiety and increased tremors Twice A Day 09:30 AM, 08:30 PM with a start date 09/09/2025 and hydrocodone-acetaminophen - Schedule II tablet; 5-325 mg; amt: 1; oral Four Times A Day 09:30 AM, 12:30 PM, 04:30 PM, 08:30 PM with a start date 10/09/2025. Review of Resident #27's care plan, dated 10/29/2024 and last revised 01/06/2026, reflected I am taking anti-anxiety medication. I take Ativan twice a day and I have complains of increased pain/discomfort and is a risk for injury from decrease in ADLs. With approaches that included Administer medication as ordered per the physician. 6. Review of Resident #34's face sheet, dated 01/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Pain in left knee, unspecified pain and spinal stenosis (a condition characterized by the narrowing of the spinal canal which can put pressure on the spinal cord and nerves causing pain). Review of Resident #34's Quarterly MDS, dated [DATE], reflected a BIMS score of 09 which indicated moderate cognitive impairment. Review of Resident #34's undated order summary reflected tramadol - Schedule IV tablet; 25 mg; amt: 1 tab; oral Special Instructions: Hold for sedation Twice A Day - PRN with a start date 11/15/2024 and tramadol - Schedule IV tablet; 25 mg; amt: 1 tab; oral Special Instructions: Hold for Sedation Twice A Day 08:30 AM, 08:30 PM with a start date 05/08/2025. Review of Resident #34's care plan, dated 04/16/2024 and last revised 12/16/2025, reflected Resident has complaints of chronic pain R/T spinal stenosis with approaches that included Administer medications. Return to assess effectiveness. 7. Review of Resident #38's face sheet, dated 01/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome (a complex condition characterized by persistent pain lasting longer than three months), Pain in unspecified shoulder, stiffness of unspecified joint, and wedge compression fracture of second lumbar vertebra (one side of the bones in the spine collapse creating a wedge shape of the lower back). Review of Resident #38's Comprehensive MDS, dated [DATE], reflected a BIMS score of 09 which indicated moderate cognitive impairment. Review of Resident #38's order summary reflected tramadol - Schedule IV tablet; 50 mg; amt: 1 tab; oral Three Times A Day 08:30 AM, 01:30 PM, 08:30 PM with a start date 12/15/2025. Review of Resident #38's care plan, dated 12/31/2025, reflected I have complains of Chronic pain syndrome/discomfort and is a risk for injury from decrease in ADLs. [sic] With approaches that included Administer medication Tramadol as ordered per the physician. 8. Review of Resident #43's face sheet, dated 01/16/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that inflames the air sacs in one or both lungs), gastroparesis (a condition in which the muscles in the stomach do not move food as they should sometimes causing pain), primary biliary cirrhosis (a progressive liver disease that causes the bile ducts in the liver to become inflamed and eventually destroyed), progressive systemic sclerosis (a rare autoimmune disease characterized by the hardening and tightening of the skin and connective tissues), and unspecified pain. Review of Resident #43's Comprehensive MDS, dated (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	searched through for the missing page. Residents chart was searched through to verify that the order was not discontinued. Verifying this would help to rule out the medication being pulled from the cart because it was discontinued. This evidence was not found as Tramadol was still an active order in the residents chart. [The DON] and [the ADON] searched thru the narcotic closet in [the ADON]'s office and it was verified that the medication card and count sheet were not in the to be destroyed medications. [The DON] began pulling the daily assignment sheets to verify who was on the medication carts for these days. The only agency nursing staff was [LVN K]. [The DON] began watching videos of the shifts that [LVN K] worked at the facility from 01/09/2026 to 01/13/2026. There were 5 shifts all together that [LVN K] worked in this time frame. Wednesday evening, it was brought to management's attention that possibly 60 tramadol doses from another hall have disappeared off the cart. The Nurse [LVN E], who brought the findings to management, remembers checking in 90 days of Tramadol for 1 resident on Monday evening shift and labeling the cards and count sheets (1 of 3, 2 of 3, and 3 of 3), However the only narcotic card and count sheet that remain on the cart and in the narcotic count book are 1 of 3. Executive Director of Operations, Administrator and DON decided to report the possible drug diversion as a self report. Police were also notified of the incident and a case number was obtained. Thursday, January 14, 2026, hours of video were watched on this day by multiple team members. Strange behavior was determined of the nurse [LVN K] while at the medication cart. [LVN K] was looking around suspiciously before unlocking the narcotic box on hall 200 cart and appeared to pop out 3 tablets from the same narcotic card but not able to visualize pill placement into a cup for administration. [LVN K] stood at the medication cart for long periods of time flipping through the narcotic sheet binder, appearing to be studying it. After rewatching the video, another management member noted [LVN K] to be writing on a paper after looking at the narcotic binder for some time, take the paper to the nurses station, use the three hole punch on the page, walk back to the medication cart and place paper in the binder. Then [LVN K] picked up what appeared to be a narcotic card and put the sheet around it. [LVN K] then gathered what appeared to be the paper, narc card, cup of water, and a medication cup and walk down hall 100 with all above in her hands. DON and ADON went to the 100 hall Narcotic book and made the discovery that [Resident #63]'s Norco sheet appeared to be have rewrote. Penmanship appeared to be the same on the top of the paper as well as the received line and the first administrations of norco were all signed out by [LVN K], however, [LVN K] did not work on some of the administration days and times at the facility. Upon pulling the narcotic card of Norco from the narcotic box, it was determined that the QTY on the label of the medication card was 90. The re-written narcotic sheet was marked with a QTY of 60. The started card had 60 doses so it appeared there was a missing card of 30 Hydrocodone (Norco) tablets. Management decided at this time to conduct a facility wide narcotic investigation. Executive Director of Operations, Administrator, and DON made copies of all narcotic count sheet and copies of all the current cards on every medications cart in the facility (6 medication carts total). DON gathered all copies and began a detailed verification of every narcotic that was signed out of the narcotic book on the current cards, were documented in the medication administration record (MAR). Narcotic Count Sheet Findings: All medications were appropriately documented in the MAR and count sheet except the following: Hall 100: [Resident #27]- Lorazepam- 1 dose signed out on 1/12/26 at 1300[01:00 PM] by [LVN K] (not medication administration time. Medication is ordered twice a day 8:30 AM and PM) [Resident #27]- Norco- 1 dose signed out on 1/11/26 at 1500 [3:00 PM] by [LVN K]. (medication is ordered every 6 hours. Previous dose was documented 4 hours prior) [Resident #27]- Norco- 1 dose signed out on 1/13/26 at 0000 [12:00 AM] by [LVN K]. (medication is ordered every 6 hours. Previous dose was documented 3.5 hours prior) [Resident #63]- Norco- This narc sheet is the one suspected to have been rewritten. Incorrect date at the top of page, documented as 11/07/2026, 6 first administrations were signed by [LVN K] on the narc sheet, however according to the MAR, the administrations were between [LVN K] and 2 other nurses. Documented QTY on Narc count sheet is 60, however according to the medication card, QTY is 90 (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. [Resident #63]- Lorazepam- Documentation of this count sheet is off, however DON was unable to determine what occurred and what exactly the nurse did. QTY is accurate and matches what the pharmacy dispensed to the facility along with the date. However, [LVN K] signed 3 consecutive administrations. According to the MAR, [LVN K] did not administer 3 consecutive doses .Hall 200: [Resident #38]- Tramadol- 1 dose signed out on 1/11/26 by [LVN K] at 1200[PM]. [Resident #88]- Oxycodone- 1 dose signed out on 1/10/26 by [LVN K] at 1200[PM]. (signed out 2 hours after last documented dose. Medication is ordered every 6 hours as needed.) [Resident #88]- Oxycodone- 1 dose signed out on 1/11/26 by [LVN K] at 0800[AM]. [Resident #88]- Oxycodone- 1 dose signed out on 1/11/26 by [LVN K] at 1100[AM]. (this dose signed out 3 hours after the previous documented dose. Medication is ordered every 6 hours as needed.) [Resident #88]- Oxycodone- 1 dose signed out on 1/12/26 by [LVN K] at 1500[3:00 PM]. (signed out 5 hours after the previous signed out dose) [Resident #88]- Oxycodone- 1 dose signed out on 1/12/26 by [LVN K] at 2200[10:00 PM]. (signed out 5 hours after the previous signed out dose) [Resident #88]- Tramadol- 1 dose signed out on 1/11/26 by [LVN K] at 0900[AM] Hall 400: [Resident #43]- Tylenol #3- 1 dose signed out on 1/13/26 by [LVN K] at 0730[AM]. [Resident #64]- Missing 2 cards of 30 tabs each of tramadol 50 mg. Received 3 cards of 30 doses each on 1/12/26 by [LVN E]. [Resident #34]- Tramadol- 1 dose signed out on 1/13/2026 by [LVN K] at 0730[AM]. Hall 500: [Resident #19]- Lorazepam- 1 dose signed out on 1/3/26 by [LVN K] at 2100[9:00 PM]. Video Findings: Video evidence shows nurse [LVN K] to be standing at the medication carts on numerous occasions flipping through the narcotic sheet binder. Saturday 1/12/26: (She=[LVN K]) [LVN K] is not assigned to a medication cart on this day. She has an assigned medication aid. 0755[AM], she is standing at the 100 medication cart flipping thru the narc binder. 0757[AM] she is writing something in the narc binder. 0758[AM] She unlocks the cart and opens the narc drawer. She appears to pull 2 cards from the narc box and pops 2 medications. At 0759[AM], she walked away from the medication cart without a cup of water or a cup of medications. At 0759.50[AM] she is back in view of the camera. 0801[AM] she walks into the medication room 0802[AM] she walks out of the medication room 0814[AM] she is standing at the medication cart again flipping thru the narcotic binder. 0823[AM] still looking through the narcotic binder 0859[AM] Medication aid brings medication cart for 200 hall back to the nurses station and plugs in the computer. 1019[AM] She is flipping through the narcotic book on 200 cart. At 1020[AM], CNA approaches [LVN K] and she closes the narc book and went to the nurses station. 1044[AM] she is at the hall 200 medication cart with the keys to the cart with the narc book open after she spoke with family member and [Resident #88]. 1045[AM] she opens the narc drawer 1046[AM] she is writing in the narc book 1047[AM] she appears to pop medications from a narc card and places them in a cup, gathers a cup of water, and takes them to the resident who is at the nurses station with her spouse and therapy. 1048[AM] She is back at the medication cart for 200 hall and appears to be writing and looking at the narcotic book. She then closes the book, unlocks the narc drawer, removes a narc card from the drawer, closes and locks the narc drawer. She then opens the narc binder, places the narc card inside of the binder, carries the narc binder to the nurses desk and appears to dump the narc card into her black bag that is under the desk. Immediately turns in her chair and takes the narc book back to the medication cart. Monday 1/12/2026: (She = [LVN K]) Numerous times she is videoed standing at the medication cart on 100 hall flipping thru the narcotic book as if studying it. Multiple times, it appears she opens the narcotic drawer but does not remove any medication for administration. 2055[8:55 PM] she opens the narcotic drawer of cart 100. Pulls out a narc card and places it on top of the cart. 2058[8:58 PM] she opens the OTC (over the counter) drawer and 2 medications and puts in medication cup. 2059[8:59 PM] She is flipping through the narcotic book again. 2107[9:07 PM] she is writing on a piece of paper on the medication cart. 2108[9:08 PM] she walks to the nurses station with the paper and locates the 3 hole punch in the drawer and appears to hole punch the new paper. She then turns and returns to the medication cart. 2109[9:09 PM] she places the new paper in the narcotic binder, removes a page from the narcotic book and places it on (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the medication cart. Then uses the keys to pen the narc drawer and remove a card which she then wraps the paper around.2110[9:10 PM] She gathers a cup of water, the medication cup, the narc card and piece of paper and walks down hall 100.Changing cameras, She can be visualized going to assist 2 CNA's with readjusting a resident in his wheelchair. She stops to talk with them, then places the cup of water, cup of medications, narc card and piece of paper at the CNA station. Once assisting the CNA's, the CNA's take the resident toward his room. She returns to the CNA station. She appears to gather her items and enter the residents room right by the CNA station (room [ROOM NUMBER]). She exits the residents room at 2020[8:20 PM] empty handed, sanitizes her hands and walks back toward the nurses station. Along the way, she stops, feels on her pant legs, turns arounds, walks a few steps back toward 109, as she continues to feel on her pant legs, she then turns back toward the nurses station, walks 2 doors down and enters another residents room for a split second before exiting. She is back in view of the camera and at the nurse station at 2122[9:22 PM]. She is joined by a CMA shortly after arriving to the nurses station.It is unclear what happened to the Narc card and sheet, but she does appear to enter room [ROOM NUMBER] possibly with them in her left hand, but does not exit with them in either hand.As for the 2 missing narcotic cards from 400 hall, there is not a camera that faces directed to the exit of the medication room on the 400 hall. However, there is a camera that faces the 300 hall side of the medication room. It is difficult to see but you can see when the medication room light turns on, which is motion sensitive.1/12/26: light turns on at 2247[10:47 PM] and turns off at 2252[10:52 PM]. Possible narc count with off going and on coming nurse.2255-2258 [10:55 PM-10:58 PM] medication room light is on.2346-0010 (11:46 PM-12:10 AM) Medication room light is on. At 2346 [11:46 PM] it appears an individual in the same colored scrubs as [LVN K] is looking thru the cabinets in the medication room.0224-0236 [02:24 AM-02:36 AM] medication room light is on0656 [AM]- medication room light is on- possibly narcotic count with off going and on coming nurse.Everything listed above is to the best of my knowledge and from visualization of documentation and watching video for hours on end.[Signed by the DON] [sic]During an interview on 01/15/2026 at 08:00 AM, the ADM stated there was a discovery of a drug diversion the previous night and the facility had identified 87 missing Tramadol pills. He stated they felt they had identified the alleged perpetrator as an agency nurse because of her acting shady on camera.During an interview on 01/15/2026 at 08:15 AM with the ADM and the DON, they stated RN F was in the facility on 01/13/2026 and discovered 24 missing tramadol pills and reported it. They stated on 01/14/2026 LVN E reported there were 2 cards equaling 60 pills of tramadol missing for a different resident. They stated the narcotic count sheets were missing as well. They stated they were still investigating the missing medications and were in the process of reaching out to all nurses and medication aides with a questionnaire. They stated [LVN K] would be included in the questionnaire process. The ADM stated a police report and self-report had been made. The ADM stated there was not any evidence to indicate any residents went without medication. He stated if the resident was out of medication, then the facility would utilize the emergency kit to obtain the needed medication.During an interview on 01/15/2026 at 11:47 AM, LVN E stated she had worked at the facility for 7 years. She stated she had been trained on abuse, neglect, exploitation and misappropriation. She stated on 01/12/2026 she received 3 cards of tramadol and on the narcotic count sheet she had labeled them 1 of 3, 2 of 3 and 3 of 3. She stated she dated and numbered the narcotic count sheets. She stated when she was counting the narcotics with another nurse on 1/13/2026 she discovered there were 2 missing narcotic medication cards and 2 count sheets for the tramadol she had received on 1/12/2026. She stated she reported it to management.During an interview on 01/15/2026 at 11:55 AM, RN F stated she worked for the facility and also for a hospice agency. She stated she performed a medication check for one of her hospice residents [Resident #3] and discovered that the narcotic log and medications were missing. She stated she had performed a medication check on 01/09/2026. She stated she immediately checked on Resident #3, then notified the DON and the ADON. She stated a refill for the medication was sent to the pharmacy to ensure Resident #3 did not go without her pain medication. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated Resident #3 had not had any changes in her demeanor. RN F stated Resident #3 did not utilize her as needed pain medication frequently, so there was no hinderance in Resident #3's care. During a phone interview on 01/15/2026 at 06:50 PM, LVN K stated she had picked up a few shifts at the facility, but she worked for an agency. LVN K stated she had been trained on abuse, neglect, exploitation and misappropriation. She stated she had worked the previous weekend, including her last shift from Monday 1/12/2026 at 3:00 PM until Tuesday 1/13/2026 at 07:00 AM. She stated she was not responsible for passing medications on that shift therefore she was not in the medication carts. LVN K stated she started working on the 100 and 200 hall at 03:00 PM and moved to 300 and 400 halls at 11:00 PM. She stated she remembered that she didn't have a medication aide for 100 hall, and she did pass medications down 100 hall until 07:00 PM or 08:00 PM that evening. LVN K stated she counted all narcotic medications with their count sheets before and after each 8-hour shift. She stated on the evening of 1/12/2026 into the morning on 1/13/2026 she did not administer any tramadol but did remember administering 2 Norco tablets and something for anxiety to Resident #63. She stated she worked on 1/10/2026 and administered Norco to Resident #63 that day as well. She stated she did not notice any medications missing from the cart. She denied seeing anyone take anything from the medication cart for personal use. She denied taking medications out of the cart for personal use. She denied administering the last dose of medication from any of the narcotic cards. During an interview on 01/15/2026 at 07:11 PM, the DON stated she had worked at the facility for 4 years. She stated she had been trained on abuse, neglect, exploitation, and misappropriation. The DON stated taking a resident's narcotic medication was a form of misappropriation. She stated if the medication was not located in the emergency medication kit, then the resident could possibly remain in pain. She stated she had reviewed video footage of what appeared to be LVN K filling out a new narcotic count sheet for an unknown medication on 100-hall. She stated she also found medications that were signed out for residents but there was no associated administration in the medication administration record. The DON stated they were initiating a new process to count the narcotic count sheets and number of narcotic cards and verify the numbers on a log for each medication cart. She stated they were still investigating the missing narcotics. During an interview on 01/16/2026 at 09:10 AM, an officer with the local Police Department stated he was at the facility to collect additional evidence related to the missing medications, but he was not the officer in charge of the investigation. He stated he would have the officer in charge of the investigation contact this investigator that evening when he arrived on shift. No call was received from the officer in charge of the investigation. During an interview on 01/16/2026 at 10:03 AM, the DON stated she would be making a referral to the Texas Board of Nursing for LVN K related to the missing narcotics. During an interview on 01/16/2026 at 10:13 AM, the ADM stated he had worked at the facility since July 1, 2025, and he was the abuse coordinator. He stated he was notified on the evening on 01/14/2026 that RN F had identified 24 missing tramadol pills for Resident #3. He stated there was an investigation started to identify where the medication went. On the evening on 1/15/2026 he stated 60 tablets of Tramadol for Resident #64 were identified as missing as well. He stated the facility then made a self-report to state agency and notified the local police department. The ADM stated through their investigation that night they were able to identify a possible alleged perpetrator. He stated the alleged perpetrator was LVN K and she worked for an agency that the facility contracted with. He stated LVN K was placed on a do not return list. The ADM stated management had started a q		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 2 of 5 medication carts (200-Hall Treatment Cart and 500-Hall Medication Cart). 1. The facility failed to ensure the 200-hall treatment cart was locked, medications and/or treatments secured, and not accessible to other staff, residents, and/or visitors. 2. The facility failed to ensure Latanoprost (a medicated eye drop used to lower the pressure inside the eye) was stored at the proper temperature per manufacturer's recommendations. These failures could place residents at risk of not receiving the intended therapeutic benefits of their medications, missing medications, and access of others to residents' medications. Findings included: During an observation on 01/14/2026 at 11:30 AM, LVN C was observed pulling supplies to perform wound care from the 200-hall treatment cart. She shut the drawer to the cart and entered a resident's room, leaving the medication cart unlocked, and shut the door to the room. During an interview on 01/14/2026 at 11:36 AM, LVN C stated she had worked at the facility for about 13 years and had been trained in securing medications. She stated it was policy to lock the treatment cart before walking away from it. She stated she forgot to lock it before going into a resident's room. LVN C stated it was important to lock the treatment cart because a resident could open the cart and take something that was not meant for them. She stated all staff monitored for unlocked medication and treatment carts when walking the hallways and performing rounds. During an interview on 01/15/2026 at 12:51 PM, the ADON stated she was assisted with training new staff. She stated it was expected for nursing staff to ensure all medication and treatment carts were locked when left unattended. She stated management monitored for ensuring medication and treatment carts were locked when they performed their walking rounds. The ADON stated any residents could possibly get into the carts and take something that was not intended for them, and it could cause harm if the medication or treatment cart is left unlocked. During an observation on 01/15/2026 at 3:12 PM of the 500-hall medication cart, an unopened bottle of Latanoprost, dated 12/12/2025, was found inside a paper bag in the bottom drawer. An unopened bottle of Latanoprost, dated 11/04/2025, was also found in a paper bag that had been stapled shut in the top drawer. Both bottles were inside boxes that stated, Store unopened bottle under refrigeration at 2° to 8° (36° to 46°). and During shipment to the patient, the bottle may be maintained at temperature up to 40° (104°) for a period not exceeding 8 days. During an interview on 01/15/2026 at 03:20 PM, MA G stated she was trained on medication storage. She stated she was trained to secure all medications behind a lock and key when walking away from the medication cart. MA G stated if a medication cart were to be left unlocked and unattended then a resident could get into the cart and take something that may injure or even kill them. She stated management monitored for locked medication carts during their walking rounds. MA G stated Latanoprost should be stored in the refrigerator until it is opened but it could be out of the refrigerator for up to 8 days prior to opening. She stated the bottles of medication found in the 500-hall medication appeared to have been delivered in November 2025 and December 2025. MA G stated both bottles of medication were unopened. She stated the medication was not stored appropriately and she would discard the medication. MA G stated the medication could lose effectiveness if not stored at the temperature stated by the manufacturer. During an interview on 01/15/2026 at 05:07 PM, the RPh stated Latanoprost was to be stored in the refrigerator until it is opened, then it could be stored at room temperature. He stated it could be stored at room temperature for up to 8 days prior to opening without affecting the integrity of the medication. He stated if the medication was not stored at the appropriate temperature prior to opening then it could decrease the effectiveness of the medication, but it would not harm the resident. During an interview on 01/15/2026 at 7:11 PM, the DON stated she (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had worked at the facility for the past 4 years. She stated the policy for securing medications required all medications to be in the medications cart and the medication locked when walking away from the cart. She stated the medication carts and treatment carts were treated the same. The DON stated if the cart was left unlocked when staff walked away, then a resident could have easy access to the contents and take something they could possibly be allergic to. She stated it was her expectation that all medications be stored at the appropriate temperature per the manufacturer's instructions. The DON stated, after reviewing the box for Latanoprost, that the medication should be stored in the refrigerator prior to opening. She stated the medication could be stored for up to eight days at room temperature prior to opening. The DON stated if the medication was not stored at the proper temperature per the manufacturer's instructions, then the medication could lose effectiveness. During an interview on 01/16/2026 at 10:13 AM, the ADM stated he had worked at the facility since July 1, 2025. He stated he expected medication and treatment carts to be locked when left unattended. He stated management monitored to ensure the carts were locked during walking rounds. The ADM stated if the carts were left unlocked then a resident who may not be of sound mind could take something from the cart that they are not supposed to. He stated, after reviewing the Latanoprost box, that the medication should be stored in the refrigerator prior to opening but could be at room temperature for up to 8 days prior to opening. He stated he was unsure how the resident might be affected if the medication was not stored according to the manufacturer's instructions. Review of facility policy titled Storage of Medications, dated 2001 and last revised April 2007, reflected Policy Statement. The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review, and interviews, the facility failed to prepare food by methods that conserve nutritive value and flavor for 1 kitchen reviewed for food and nutrition services. The facility failed to ensure DM B refrained from adding an unmeasured amount of liquid to Salisbury steak with gravy, seas white beans, and sauteed cabbage pureed meals during lunch service on 01/14/2026. This failure could place residents who received a pureed diet at risk for diminished or altered nutritional status and potential weight loss. Observation and interview of the pureed diet process, on 01/14/2025, at 11:09 AM, revealed DM B poured an unmeasured amount of chicken broth into the sea beans without measuring after mixing one time, she poured the beans into a serving pan, the beans were runny in appearance. DM B proceeded to puree the sauteed cabbage which appeared to be over boiled instead of sauteed. DM B poured another unmeasured amount of chicken broth from a plastic container into the blender with the cabbage. After mixing the first time, she added another unmeasured amount of chicken broth into the mixture. When DM B poured the cabbage into the serving dish, it had a watery consistency. DM B pureed the ground meat for the Salisbury Steak next in which she poured unmeasured amounts of beef broth from a container into the meat. The first blend was a thin texture; she added more beef and then more unmeasured beef broth. DM B poured the steak in a serving container; it was not of a pudding consistency texture. When she was done, Surveyor mentioned to DM B that the meal items had a thin consistency, she responded, they will thicken while sitting on the steam table. DM B was asked how much liquid was used per serving, she responded she did not know how much was used. DM B stated, This is the way I do it all the time, I don't measure. I put everything in the blender for about 5-8 cups and then add broth. Surveyor asked DM B if she had followed the recipe book, she stated they do not have recipe books, they printed the recipes off the computer. DM A provided surveyor with a copy of the recipes for the day. The recipe showed the meat, beans, and cabbage should be processed in 5 portions at a time as needed. The recipe showed the meat should be pureed to a pudding consistency. The cabbage recipe showed the sauteed cabbage should have included green pepper, onions, garlic cloves, and sliced bacon, but omit the bacon on the puree serving. A Test tray was requested and received on 01/14/2026 at 12:40 PM. The meal was Salisbury steak with gravy, seas white beans, sauteed cabbage, and cornbread. A test tray was received for a regular texture diet and puree diet. The Salisbury steak, the cabbage, and beans on the puree diet plate all had excess liquid, neither item was of a pudding like texture, the cornbread was the only item with pudding like texture. The meat had flavor, but the other items tasted bland. The regular diet plate was tested, and the meat was tasty but a little rubbery, the sauteed cabbage was bland and had no flavor, there was no indication that green pepper, onions, garlic cloves, and sliced bacon had been used in the recipe. During a confidential group interview meeting at an undisclosed date and time, 3 anonymous residents stated lunch today had no taste. One anonymous resident stated, Everything was white, meals are supposed to have colors. An attempted interview on 01/15/2026 at 4:15 PM, with DM B, was unsuccessful, she had left for the day. Interview conducted with the [NAME] on 01/15/2026, at 4:16 PM. The [NAME] stated he has worked as a cook with the facility since April 1st, 2025. The [NAME] stated he was trained on puree diets by a previous dietary manager who no longer works at the facility. The [NAME] stated he uses one third cup of thickener depending on the recipe. He stated he uses a little scoop of it at a time when blending. He stated the residents do not like it too thick, so he listens to what the residents say also. The [NAME] stated the puree food items should be like pudding, not too runny and not too thick. The [NAME] stated he followed the recipe book and stated if the residents did not eat their food, they could lose weight and possibly get sick. Interview conducted with DM A on 01/15/2026, at 4:40 PM. DM A stated she has worked at the facility for 2 years and she became the dietary manager in July 2025. DM A stated the cooks are trained by the dietician in preparing diet textures. DM A stated she does not personally prepare pureed diets. She stated DM B has been provided training on pureed diets with the dietitian. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Spjst Rest Home 1		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 Old Granger Road Taylor, TX 76574	
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated the DM B reviews the recipe if she has not prepared it before or recently. She stated the pureed texture should be smooth and hold its shape, like pudding. She stated her expectation is that measuring cups be used when preparing food products. She stated that if a recipe is not followed, a resident could be at risk for choking or weight loss. Interview conducted with the ADM on 01/15/2026, at 6:23 PM, ADM stated his expectation was for dietary staff to follow the recipes as written. He stated he does not train the kitchen staff, but they have a dietician that comes to the facility monthly. ADM explained that if the pureed diet was not prepared according to the recipe, the food could lose its flavor and not taste good. He stated the potential harm to residents was that they may possibly stop eating and the residents could lose weight. Interview conducted with the DON on 01/15/2026, at 6:39 PM. DON was asked, how are physician-ordered diets (such as pureed diets) communicated to nursing and dietary staff. DON stated the SLP initiated the recommendation which is sent to the physician. DON stated the recommendations are returned to her and the ADON and they send a communication slip to the kitchen. DON was asked what systems are in place to ensure residents consistently receive the prescribed diet texture, she responded that the servers prepare the plates, tray ticket and food consistency is verified by the nurse before being given to the residents. DON stated she expects the dietary department to follow the recipes. DON stated if a puree diet recipe was not followed, residents could potentially choke, not receive the right amount of nutrients or lose calories if too much liquid was used. DON also stated too much liquid could cause aspiration. A follow up interview was conducted with DM B on 01/16/2026, at 10:11 AM. DM B stated she was employed at the facility for 6 years but just returned March 2025. DM B stated no one trained her in the pureed process, she mostly taught herself. She stated a dietician comes and checks the food. When asked why a physician orders a pureed diet, DM B stated that some residents have swallowing issues with regular food and require specific textures to eat safely. When asked how she ensures the correct texture and consistency, she stated that when the food is poured into the pan it should not be lumpy, too thick, or too runny. Surveyor showed DM B pictures of the pureed meal served on 1/14/2026, she stated she was nervous on that day. DM B stated she will be looking more closely at the recipes. When asked what risks could occur if the pureed diet is not prepared according to the recipe, the DM B stated that the resident could choke if the texture is incorrect and that this could cause harm to the resident. Record Review of the facility's puree diets received 1/14/2026 from ADM revealed there were 11 residents on pureed diets. Record Review of the facility policy Therapeutic Diets dated October 2017 states: Policy Statement Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. Policy Interpretation and Implementation 1. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet. 2. A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). The attending physician may delegate this task to a registered or licensed dietitian as permitted by state law. 3. Diet order should match the terminology used by the food and nutrition services department. 4. A 'therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: a. ~diabetic/calorie controlled diet; b. ~low sodium diet; c. ~cardiac diet; and d. ~altered consistency diet. 5. ~If a mechanically altered diet is ordered, the provider will specify the texture modification. 7. ~The dietitian, nursing staff, and attending physician will regularly review the need for, and resident acceptance of, prescribed therapeutic diets. 8. ~The dietitian and nursing staff will document significant information relating to the resident's response to his/her therapeutic diet in the resident's medical record. 9. ~Snacks will be compatible with the therapeutic diet.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to maintain an infection prevention and control program, including hand hygiene and enhanced barrier precautions, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 8 (Resident #3, Resident #15, Resident #26, Resident #29, Resident #41, Resident #58, Resident #69 and Resident #87) of 23 residents reviewed for infection control practices, in that: The facility failed to:1. Ensure LVN C practiced proper hand hygiene while serving and assisting Residents #15, # 29, #58, # 69, and #87 during the lunch meal on 01/13/2026.2. Ensure LVN C and CNA I practiced proper enhanced barrier precautions by wearing the appropriate personal protective equipment when performing wound care for Resident #3 on 1/14/2026.3. Ensure LVN C practiced proper hand hygiene while assisting Resident #58 during the lunch meal on 01/14/2026.4. Ensure LVN D and CNA E practiced proper hand hygiene while assisting residents #26 and #41 during the lunch meal on 01/15/2026. These failures could place residents at risk for healthcare associated cross-contamination and infections. 1. An observation of the lunch meal on 01/13/2026 of satellite kitchen area 100/200 between 12:35PM and 1:20PM revealed LVN C serving and assisting with the lunch meal. At 12:41 PM, LVN C was observed to prepare a plate for Resident #87. During food preparation, LVN C scratched her head with her right hand and continued handling the plate without performing hand hygiene. At 12:43 PM, LVN C scratched her nose while continuing to prepare the same plate, then covered the plate and provided it to a staff member for transport to room [ROOM NUMBER] for Resident #87. At 12:51 PM, LVN C donned a blue glove on her right hand without performing hand hygiene and handed Resident #58 a sandwich. LVN C then sat with a resident for approximately five minutes and scratched underneath her scrub top with her left hand. Upon leaving the table, LVN C disposed of the glove in a trash receptacle and did not perform hand hygiene. At 12:59 PM, LVN C gathered a plate for Resident #29 without performing hand hygiene. At 1:16 PM, LVN C sat at the table with Resident #29 and #69 then at 1:17 PM, LVN C wiped the mouth of Resident #69 using the resident's clothing protector. At 1:18 PM, LVN C picked up a drink and handed it to Resident #15 without performing hand hygiene between resident contacts. 2. Review of Resident #3's face sheet, dated 01/15/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included pressure ulcer of sacral region (opening in skin due to pressure to lower back/buttock area), unspecified pain, and retention of urine. Review of Resident #3's Quarterly MDS, dated [DATE], reflected a BIMS score of 01 which indicated severe cognitive impairment. Review of Resident #3's undated order summary reflected Enhanced Barrier Precautions: wear PPE with all care. Every Shift with a start date 07/30/2025. An observation on 01/14/2026 at 11:26 AM revealed LVN C and CNA I washed hands, applied gloves and approached Resident #3 to start wound care. Neither LVN C nor CNA I put on a gown prior to providing wound care. CNA I assisted with positioning and verbally comforting Resident #3 while LVN C performed wound care to Resident #3's lower back/buttock area. A sign was observed outside the resident's door that indicated Resident #3 required Enhanced Barrier Precautions with a 3-drawer tote inside Resident #3's room that contained gowns and gloves. During an interview conducted on 01/14/2026 at 11:36 AM, LVN C stated she had worked at the facility for 13 years. She stated she had been trained on infection prevention and control. She stated she forgot to wear the proper enhanced barrier precautions that included a gown when performing wound care for Resident #3. She stated enhanced barrier precautions were used to prevent transmitting bacteria and infection to or from the resident. She stated she was not sure if anyone monitored to ensure the proper precautions were being utilized. During an interview conducted on 01/14/2026 at 11:43 AM, CNA I stated she had been trained on infection prevention and control including the use of enhanced barrier precautions. She stated enhanced barrier precautions were used for the safety of the resident to prevent transmission of infections. She stated she did not wear a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown while performing care to Resident #3. She stated she forgot to wear a gown while assisting LVN C with wound care for Resident #3. 3. An observation of the lunch meal on 01/14/2026 of satellite kitchen area 100/200 between 12:50 PM and 1:15PM revealed LVN C to walk from hallway 100 over to the satellite dining area. LVN C removed a blue glove from the kitchen area and donned the glove on her right hand without performing hand hygiene. She then approached the table of Resident #58, handed the resident half of a sandwich, and sat at the table with the resident. At 1:05 PM, LVN C removed the blue glove and held it balled up in her hand. She was then observed to wipe Resident #58's mouth with the same hand where the glove was balled. No hand sanitizing observed. She then proceeded to escort the resident to the TV area. 4. An observation of the lunch meal on 01/15/2026 of satellite dining area 400 between 12:45 PM and 1:20 PM revealed: At 12:45 PM, CNA E was observed seated and providing feeding assistance to two residents simultaneously, Resident #26 and Resident #41 without performing hand hygiene between contacts. At 1:03 PM, LVN D was observed walking from the middle of the dining area 400 to the table where Residents #26 and #41 were seated. LVN D asked CNA E to take over feeding one of the residents and assumed feeding assistance for Resident #41 without performing hand hygiene prior to contact. At 1:18 PM, LVN D was observed removing keys from her pocket with her right hand and handing them to another staff member. LVN D then resumed feeding Resident #41 without performing hand hygiene. During an interview on 01/15/2026 at 12:28 PM, the ADON stated she was responsible for the infection prevention and control program. She stated it was her responsibility to train staff on proper infection prevention policies. She stated she had done an in-service related to enhanced barrier precautions when it was initiated, but it had been a while. She stated enhanced barrier precautions were used if a resident had an open wound, foley catheter, central line, and/or a multi-drug-resistant organism. She stated it was expected for staff to use a gown and gloves when providing any hands-on care to a resident that had the previously listed conditions. The ADON stated enhanced barrier precautions were used to keep from transmitting infections from resident to resident. She stated she monitored this when she was walking around the facility, but it could be monitored more closely. She stated any staff providing hands-on care to a resident with a wound was expected to wear a gown and gloves. The ADON stated by not wearing gowns and gloves to provide care to a resident with an open wound, the resident is already at risk and the staff could give the resident an infection transmitted on their clothing. An interview conducted with LVN D on 01/15/2026 at 5:33 PM revealed she was trained on proper hand hygiene. She stated that she has been working at the facility for 6 years. The surveyor informed LVN of observations where she failed to wash or sanitize her hands-once when she sat to feed Resident #41 and another time when removing keys from her pocket and continued to feed Resident #41. LVN D stated she sanitized her hands before she sat to feed resident, she stated she stopped to speak with a staff member on the way and did not recall touching anything prior to sitting at the table. LVN D stated she clearly remembered that she removed the keys from her pocket without using sanitizer. LVN D stated a resident can obtain an infection from not performing proper handwashing. An interview conducted on 1/15/2026 at 5:41 p.m., CNA E stated that she has been working at the facility for almost two years. When asked if she had received training on hand hygiene and assisting residents during dining, she confirmed that she had been trained in proper handwashing procedures. She stated that she typically used hand sanitizer, but she knew today she did not. CNA E stated she tried very hard to make sure that the utensils for Residents #26 and #41 did not touch anything but their food and their mouths. She stated she wished they had more staff to feed the residents. CNA E stated bacteria can be transferred to a resident from not using proper hand hygiene, which could cause a resident to become sick. An interview conducted on 1/15/2026 at 6:00 PM, LVN C revealed she was trained in proper hand hygiene. LVN C was informed of the observations in which she failed to perform hand hygiene on 1/13/2026 while serving and assisting Residents # 15, # 29, 58, 69, and #87. LVN C stated she believed she sanitized her hands between the residents, she stated it was a busy day, and she did not remember. LVN C stated on 1/14/2026 she only recalled assisting (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one resident which was Resident #58, she stated she did not recall holding the glove in her hand because she knew it went in the trash. LVN C acknowledged that failure to perform proper hand hygiene could lead to cross contamination and potential illness. During an interview on 01/15/2026 at 07:11 PM, the DON stated she had worked at the facility for 4 years. She stated she was trained on infection prevention and control policies, including enhanced barrier precautions. The DON stated any resident who had any open areas required the use of enhanced barrier precautions, including a gown and gloves, when staff provided hands-on care. She stated she expected staff to use enhanced barrier precautions including the use of gown and gloves to prevent transmission of bacteria to residents who had any open areas. The DON stated there had not been any recent monitoring of staff to ensure they were utilizing enhanced barrier precautions appropriately, but she had performed checkoffs and in-services related to enhanced barrier precautions within the past year. During an interview on 01/16/2026 at 10:13 AM, the ADM stated he had worked at the facility since July 1, 2025. He stated he had been trained in infection prevention and control policies, including enhanced barrier precautions. He stated he was unsure of the reasoning for implementing enhanced barrier precautions, but the residents that required it had signs posted on their door and supplies just inside of their rooms. The ADM stated residents with signs posted required anyone providing hands on care to utilize gowns and gloves to prevent any possible infection to or from the residents. He stated he was unsure if there was any monitoring in place to ensure enhanced barrier precautions were being utilized appropriately. Record review of facility policy Handwashing/Hand Hygiene revised August 2015 read: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. 6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a. When hands are visibly soiled; and b. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc. 1. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; and q. After personal use of the toilet or conducting your personal hygiene. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Review of facility policy titled Enhanced Barrier Precautions, dated 2021 and last revised December 2025, reflected Policy Statement Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to treat each resident with respect and dignity and failed to provide care for each resident in a manner and environment that promoted the maintenance or enhancement of their quality of life for 2 (Resident #26, Resident #41) of 12 residents reviewed for dignity. The facility failed to ensure that Resident #26 and Resident # 41 were provided dignified and individualized feeding assistance during the lunch meal on 01/15/2026. This failure could place residents at risk of diminished dignity and negatively affect their quality of life. Record review of Resident #26's Face sheet dated 01/15/2026, reflected she was a [AGE] year-old female, who was admitted to facility on 03/09/2021 with diagnoses of Hypertensive heart disease with heart failure (high blood pressure damaged the heart), Neurocognitive disorder with Lewy bodies (brain condition that cause problems with memory), Unspecified dementia (memory loss), Major depressive disorder (feel sad, hopeless), and Vitamin deficiency. Record review of Resident # 26's MDS assessment, dated 11/20/2025, indicated a Brief Interview for Mental Status (BIMS) was not conducted. The Staff Assessment for Mental Status revealed a score of 3 indicating severely impaired cognition (never/rarely made decisions). Record review of Resident # 26's care plan, dated 11/28/2025 reflected Nutritional Status: I am in need of a special utensil to assist with meal time. I need a high sided plate to help with getting the food on my utensil I will be able to assist myself at mealtimes thru this review period. Monitor effectiveness of the utensil, notify physician of any significant changes. Record review of Resident #41's Face dated 01/15/2026, reflected she was an [AGE] year-old female, who was admitted to facility on 05/18/2021 with diagnoses of Alzheimer's disease with late onset (brain disorder slowly destroys memory), Gastro-esophageal reflux disease without esophagitis (stomach acid flows back into the esophagus), Anorexia (no desire to eat, leading to weight loss), and Unspecified dementia (memory loss). Record review of Resident # 41's MDS, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) was not conducted. The Staff Assessment for Mental Status revealed a score of 3 indicating severely impaired cognition (never/rarely made decisions). MDS also indicated Resident #41 required total assistance with eating. Record review of Resident # 41's care plan dated 12/16/2025 reflected resident has a nutritional problem with the potential for unintended weight loss related to requiring assistance with meals and poor intake. Resident #41 should have assistance with her meals and fluid intake during mealtimes. Observation of the facility's dining room [ROOM NUMBER] on 01/15/2026 between 12:45 PM and 1:20 PM, revealed that at 12:45 PM, Resident #26 and Resident #41 were being fed their lunch meal at the same time by CNA E. Resident #26 and Resident #41 was observed waiting on their food while CNA E assisted the other resident, resulting in delayed assistance and individualized care. CNA E did not wash her hands, nor did she use any hand sanitizer at the table between the two residents. Continued observation on 12/2/2025 at 1:03 PM revealed LVN D walked over and asked CNA E to take over feeding of Resident #41. Interview conducted 1/15/2026, at 1:47 PM, revealed SLP had worked for four months at the facility. SLP stated she was aware residents had the right to be treated with dignity and respect during meals. SLP stated she could not say that feeding two residents at the same time was a rights violation unless the residents were documented as needing required feeding assistance. She stated it would be a cross-contamination concern. SLP stated a resident would be assessed on a resident-specific basis. Regarding if it was a safety concern, SLP stated, it depends on whether a resident was considered a high risk at mealtimes. She added that feeding two residents at the same time could cause the residents to feel confused or left out. Interview conducted 1/15/2026, at 5:33 PM, revealed LVN D had been working for almost 6 years at the facility. LVN D stated she has been trained on the facility's abuse and neglect, resident rights, and promoting/maintaining resident dignity procedures. LVN D revealed she was aware residents had (continued on next page)		

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the right to be treated with dignity and respect during meals. LVN D stated she witnessed the incident involving Resident #26 and Resident #41 being fed at the same time. LVN D stated she did not believe feeding two residents at the same time to be a rights or dignity violation; however, she stated she could see how it could be a problem. LVN D stated that residents should have the right to eat in a safe environment. She further stated feeding two residents at the same time could make a resident feel abandoned. Interview conducted 01/15/2026 at 5:41 PM, with CNA E revealed she worked as a CNA for almost 2 years with the facility. CNA E stated she has been trained on the facility's abuse and neglect, resident rights and dignity by the DON and other facility staff. CNA E stated it was not appropriate to feed two residents at the same time. CNA E acknowledged she fed two residents today at the same time while waiting on another staff to assist. CNA E stated she prefers to feed only one resident at a time; however, she stated she wished the facility had more staff available to assist with feeding. CNA E stated a facility staff could accidentally use the same feeding utensils for both residents, which would create a cross-contamination issue as well as a dignity concern. CNA E stated the possible effect on the residents is that the residents could feel upset because the focus is not on them individually. Interview conducted 01/15/2025 at 6:18 PM, the ADM stated he has been with the facility since July 1, 2025. ADM stated that all administrative staff were responsible for training staff in resident rights and dignity policies. The ADM stated staff should only feed one resident at a time to ensure a safe dining environment. The ADM stated the situation is a Catch-22 and mentioned that he was unsure of it being a rights violation, but dignity concerns could go either way. When asked about residents' right to a safe environment during mealtimes, ADM stated residents had the right to eat in a safe environment. He stated if a resident aspirated or choked while staff helped another resident it would not be a safe environment. The ADM stated this practice, could cause a resident to think, why they have to wait. Record review of the facility's policy on Resident Rights, dated October 2025, stated: Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms; e. self-determination; Record review of the facility's policy on Dignity, dated October 2025, stated: Policy Statement Residents are treated with dignity and respect at all times. Policy Interpretation and Implementation 1. Each resident is cared for in a manner that promotes and enhances individuality, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem. 2. Resident goals, choices, preferences, values, and beliefs are respected and honored to the extent possible. This begins with the initial admission and continues throughout the resident's facility stay. 3. Individual needs and preferences of the resident are identified through the comprehensive assessment process, which includes resident and family interviews. 4. Residents may exercise their rights without interference, coercion, discrimination, or reprisal from any person or entity associated with this facility. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are encouraged to: a. maintain personal grooming styles (e.g., hair styles, nails, etc.); b. attend the activities of their choice, including religious, political, civic, recreational, or social activities; c. dress in clothing they prefer; and d. sleep, eat, and conduct activities of daily living as they choose. 9. Staff inform and orient residents to their environment. Procedures are explained before they are performed and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings. 13. Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: a. addressing the underlying motives or root causes for behavior; and not challenging or contradicting the resident's beliefs or statements.		