

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: 676298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Spjst Rest Home No 2		STREET ADDRESS, CITY, STATE, ZIP CODE 8611 Main St Needville, TX 77461	
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy for 1 of 4 residents (Resident #6) reviewed for privacy. The facility failed to ensure LVN F closed Resident #6's privacy curtain and room door while providing G-tube medication and feeding for the resident. This failure could have placed residents at risk for loss of self-esteem, self-worth, and dignity. Findings included: Record review of Resident #6's face sheet dated 12/04/25 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. He had a diagnosis included moderate protein-calorie malnutrition (person not getting enough essential nutrients for the body to work well), malignant neoplasm of the hypopharynx (cancer that grows in the lower part of the throat), and gastrostomy tube (a tube inserted through the abdominal wall used for delivering liquid food and medication). Record review of Resident #6's annual assessment MDS dated [DATE] revealed a BIMS of 03 out of 15, which indicated severely impaired cognition. It also showed Resident #6 was dependent on staff for feeding. Further review revealed the resident had a G-tube for feeding. Record review of Resident #6's care plan dated 10/29/23 showed the resident was receiving G-tube feeding. Intervention: Check placement and patency of feeding tube before each feeding or medication administration. Check gastric residuals as ordered by MD. Assess for /anxiety/depression, aspirations, self - extubation, fever, pneumonia, SOB, displacement into lungs, abdominal distension/pain. During an observation on 12/03/25 at 9:12 a.m., it was observed that LVN F did not close the privacy curtain or Resident #6's room door while she administered medication and feeding through the resident's G-tube, and his abdominal area was exposed. Staff and other people walked past Resident #6's door and were able to see his exposed abdominal area. CNA E passed by the resident's door and called out to the surveyor, saying she was waiting for the surveyor. During an interview on 12/03/25 at 10:00 a.m., Resident #6 said he would have preferred the privacy curtain to be pulled during medication and feeding to prevent people walking past his room from seeing him, because he could see the people passing and they could see him too. During an interview on 12/03/25 at 10:06 a.m., CNA E said she saw Resident #6's exposed abdomen when she walked past his room twice, and that was when she told the surveyor she was waiting for her. She said LVN F was supposed to close the door and the privacy curtain to prevent anybody from seeing Resident #6's exposed abdomen because it was a dignity issue and Resident #6 could have felt bad. During an interview on 12/03/25 at 1:15 p.m., LVN F said she did not close Resident #6's room door or pull the privacy curtain. She said Resident #6's abdomen was exposed and anybody who walked past the resident's room door could have seen the resident. LVN F said it was a dignity issue, and the resident would not have felt good when other residents saw his exposed body. She said she should have closed the door or at least pulled the privacy curtain. During an interview on 12/05/25 at 3:55 p.m., the MDS said LVN F should have closed the door and pulled the privacy curtain to prevent Resident #6 from being exposed. She said it was a dignity issue because the staff, other residents, and visitors could have seen Resident #6 exposed, and Resident #6 would have been upset. During an interview on 12/05/25 at 4:10 p.m., the DON said LVN F should have pulled the privacy curtain and closed the door before she exposed Resident #6's G-tube site for medication administration and feeding. She said by (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pulling the privacy curtain and closing the door, LVN F would have provided privacy for the resident. She said it was a dignity issue because the door and the privacy curtain were left open and anybody who walked past the resident's room door would have seen the exposed abdomen, and Resident #6 would not have felt good about being exposed. During an interview on 12/05/25 at 4:35 p.m., the Administrator said LVN F was supposed to close the privacy curtain and Resident #6's room door to provide privacy for the resident during medication and feeding through a G-tube. She said the resident would have been upset because he was exposed, and it was a dignity issue. Record review of the facility policy on resident right dated 2001 MED - PASS, Inc read in part . employees shall treat all residents with kindness, respect and dignity. policy interpretation.guarantee certain basic rights to all residents of this facility. #1t. privacy and confidentiality.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 4 residents (Resident #31) reviewed for incontinent care. The facility failed to ensure CNA E properly cleaned Resident #31 during incontinent care when CNA E did not separate Resident #31's labia on 12/03/2025. This failure could have placed residents at risk for pain, infection, injury, and hospitalization. Findings included: Record review of Resident #31's face sheet dated 12/04/25 revealed an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: hypertension (when the blood pushing against the artery walls is constantly too high), dementia (decline in mental ability severe enough to interfere with daily life), and senile degeneration of the brain (breakdown of brain cells causing a serious decline in memory, thinking, and ability to do daily tasks). Record review of Resident #31's annual assessment MDS dated [DATE] revealed a BIMS of 03 out of 15, which indicated severely impaired cognition. It also showed Resident #31 was dependent on staff for bed mobility. Further review revealed the resident was incontinent of bowel and bladder. Record review of Resident #31's care plan dated and edited 08/01/25 read in part, . resident experiences bladder and bowel incontinence. Approach: Provide incontinence care after each incontinent episode. Apply skin barrier cream to peri area to prevent feces or urine from causing skin breakdown. During an observation on 12/03/25 between 10:16 a.m. and 10:35 a.m., incontinent care provided for Resident #31 by CNA E revealed CNA E wiped Resident #31's left peri area once, and there was bowel movement. CNA E did not separate her labia, and she turned the resident to the right and wiped the buttocks and rectum. She pulled out the soiled incontinent brief and applied a clean incontinent brief and was about to fasten the brief when the surveyor intervened. Then CNA E separated Resident #31's labia and cleaned the labia four times, and there were bowel movements; on the fifth wipe, the wipe was clean. During an interview on 12/03/25 at 10:40 a.m., CNA E said she should have separated Resident #31's labia and cleaned until there was no bowel movement. She said if she did not clean Resident #31's labia properly, the resident could have gotten an infection, rashes, or skin breakdown. CNA E said she should have cleaned the peri area first before she turned the resident to her side and cleaned the buttocks area. During an interview on 12/03/25 at 10:42 a.m., LVN B said CNA E should have separated Resident #31's labia and cleaned until there was no bowel movement to prevent Resident #31 from getting an infection (UTI) or skin breakdown. During an interview on 12/05/25 at 4:09 p.m., the MDS said CNA E should have separated Resident #31's labia area and cleaned one side with one wipe, the other side with another wipe, and the middle, and also assessed the skin area. She said if CNA E did not clean the labia area properly, the resident could have gotten an infection. During an interview on 12/05/25 at 4:26 p.m., the DON said CNA E should have separated Resident #31's labia and cleaned with one wipe once and thrown it away, then another wipe for the other side and used another wipe for in the middle area. The DON said Resident #31's labia should have been separated and the area cleaned appropriately, and if it was not, the resident could have gotten an infection. During an interview on 12/05/25 at 4:33 p.m., the Administrator said CNA E should have separated Resident #31's labia during incontinent care to make sure the area was clean to prevent infection. Record review of the facility policy on perineal care dated 2001 MED-PASS, Inc. read in part, .Purpose: the purposes of this procedure were to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. For a female resident. #8b1. Separate labia and wash area downward from front to back. Rinse perineum thoroughly.		