

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: 455906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Lone Star Rehabilitation & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Senator Robert J Glasgow Loop Stephenville, TX 76401	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and record reviews, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property for 4 of 16 employees (SW, ADMN, CNA C and CNA D) reviewed for employability. The facility failed to ensure record of criminal history check and/or an EMR/NAR check prior to hire were maintained for the SW. The facility failed to ensure record of annual EMR/NAR checks were maintained for the (SW, ADMN, CNA C and CNA D). These findings placed residents at risk of receiving care by someone that was unemployable. The findings included: Record review of the SW's employee file revealed a hire date of 03/28/2022 and no evidence of a criminal history or an EMR/NAR check were completed prior to hire. Further review revealed no evidence of annual EMR/NAR check was completed annually. Record review of the ADMN's employee file revealed a hire date of 02/07/2023 and no evidence of an annual EMR/NAR check completed annually. Record review of the CNA C's employee file revealed a hire date of 03/30/2023 and no evidence of an annual EMR/NAR check completed annually. Record review of the CNA D's employee file revealed a hire date of 11/11/2022 and no evidence of an annual EMR/NAR check completed annually. During an interview on 09/04/2025 at 1:10 PM Payroll E stated she had only been in the position since March 2025. Payroll E stated she was responsible for completing criminal history and EMR/NAR checks. Payroll E stated criminal history checks and EMR/NAR checks were supposed to be completed prior to hire and EMR/NAR checks were supposed to be completed annually. Payroll E stated she had been working since March 2025 and that when she started at the facility, she was told to upload employee files to electronic files. Payroll E stated she uploaded all the documents could find. During an interview on 09/04/2025 at 1:45 PM the ADMN stated her expectation was criminal history checks and EMR/NAR checks were supposed to be ran prior to hire and EMR/NAR check should have been ran annually at date of hire. The ADMN stated Payroll was responsible for ensuring Criminal/EMR NAR checks were to be completed prior to hire and EMR/NAR checks were to be ran annually upon anniversary date. The ADMN stated she was ultimately responsible to ensure checks were completed. The ADMN stated residents could have been affected by being exposed to staff who should not have been hired. The ADMN stated what led to failure was turnover in the payroll in position. The ADMN stated she felt they were completed but the facility had started having employee files uploaded electronically and documents may have been misplaced. Record review of facility policy titled, Personnel Records dated 2/17/2023 revealed: A separate confidential folder will be maintained in conjunction with the personnel contents of payroll record folder and will contain the following confidential information: .a. Criminal History Check (completed prior to hire) . d. Misconduct Registry and Nurse Aide Registry Checks (completed prior to hire and annually)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Lone Star Rehabilitation & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Senator Robert J Glasgow Loop Stephenville, TX 76401	
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 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 observation, interview and record review, the facility failed to ensure that each resident received food that was palatable, attractive and at a safe and appetizing temperature of 1 of 1 lunch meal in 1 of 1 kitchen tested for nutritive value, flavor, and appearance. The facility failed to provide palatable food served at an appetizing temperature to residents, during lunch on 09/03/2025. This failure could affect the residents who ate food from the facility kitchen by placing them at risk of poor food intake and/or dissatisfaction of meals served. The findings included: During an observation on 09/03/2025 at 12:37 PM the DM obtained food temperatures for noon meal that consisted of Jambalaya, Boiled okra, Cornbread. The temperature of the boiled okra was 115 degrees and was not warm or palatable when eaten by 3 surveyors. During an interview on 09/03/2025 at 12:40 PM the DM stated the boiled okra should have been warmer. The DM declined tasting the meal. During a confidential meeting on 09/03/2025 at 3:01 PM 6 residents voiced complaints concerning food. The residents stated the food was served cold and did not have any flavor. The residents stated that the meat was tough and hard to eat. During an interview on 09/04/2025 at 9:26 AM the Dietician stated her expectations was that the meals would be served on time and at a palatable temperature. The Dietician stated the residents could be affected by not wanting to eat late and be upset that meal was not served on time. The Dietician stated if the meal was not warm it may not be palatable to a resident. The Dietician stated her expectations were that all residents would be served warm and palatable meals. The Dietician stated she was not aware of meals being served late. She stated her expectations were that meals be served on time. During an interview on 09/04/2025 at 9:57 AM the DM stated the boiled okra served on lunch meal on 09/03/2025 should have been warmer to be palatable. The DM stated her expectations were that all meals be served at an appetizing temperature. The DM stated meals being served cold could cause the resident to not want to eat. The DM stated she did not know why this failure occurred. The DM stated the cook and herself were responsible to ensure all meals are served at an appetizing temperature. During an interview on 09/04/2025 at 12:54 PM the ADMN stated that her expectations was that all meals be served at an appetizing temperature. The ADMN stated if the food is served cold the resident would not want to eat and this could lead to weight loss. The ADMN stated it was the responsibility of the cook and DM to ensure that all meals are served at a palatable and appetizing temperature. The ADMN stated she did not know what caused this failure to occur. During a review of facility's grievance log on 09/04/2025 at 10:10 AM revealed a grievance on 07/25/2025 was filed due to lunch meal served at 1:00 PM and supper at 6:00 PM. Grievance filed on 06/16/2025 stated food is cold when served to residents. Grievance filed on 03/10/2025 stated meals are cold. During a record review of the facility's policy titled: Food: Preparation revised 2/2025: All foods are prepared in accordance with the FDA Food Code. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F or per state regulation. All foods will be held at appropriate temperatures, greater than 135 degrees F for hot holding, and less than 41 degrees F for cold food holding. Temperature for TCS (Time/Temperature Control for Safety) will be recorded at time of service and monitored periodically during meal service periods.		

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: 455906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Lone Star Rehabilitation & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Senator Robert J Glasgow Loop Stephenville, TX 76401	
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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents receive meals at regular times comparable to normal mealtimes in the community, for 1 of 1 meal observed for meal service. The facility failed to ensure meals were consistently served at posted mealtimes (lunch meal on 09/02/2025). Posted meal times: Breakfast-Assisted dining room [ROOM NUMBER]:00 PM, Main Dining room [ROOM NUMBER]:05 PM, Hall Trays 12:40 PM This failure could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for decreased meal satisfaction, decreased intake, loss of appetite, unplanned weight loss, and side effects from medication given without food, and diminished quality of life. Findings included: During an observation on 09/02/2025 at 7:30 AM of posted mealtimes in dining room: Lunch Delivery begins at 12:00 PM. The first cart of trays is delivered to the assisted dining room. Assisted Dining room [ROOM NUMBER]:00 PM, Main Dining room [ROOM NUMBER]:05 PM, Hall trays 12:40 PM. During an observation on 09/02/2025 at 12:00 PM the staff began checking the temperature of meal being served. The dietary staff had to keep checking the temperature of tuna salad and other salads being served at the lunch meal and having to place all of the salads back into the refrigerator to obtain safe serving temperatures. During an observation on 09/02/2025 at 12:50 the kitchen staff began plating lunch meal. The last hall tray was served on Hall 3 at 2:14 PM. During an interview on 09/04/2025 at 9:26 AM the Dietician stated her expectations were that all meals be served on time per facility's posted times. The Dietician stated the residents could be affected by late meals, by not wanting to eat and being upset that meal was served late. The Dietician stated this failure may have occurred due to the difficulty to keep a cold meal cold and at safe temperatures. The Dietician stated the DM and cook are responsible for ensuring meals are served on time. The Dietician stated she had not been aware of any meals not being served in a timely manner. During an interview on 09/04/2027 at 9:57 AM DM contributed the meal service on Tuesday (9/02/2025) being served late due to the meal consisting of all cold entrees and salads. The DM stated it can be difficult to get salads, tuna fish to appropriate/safe temperature. The DM stated her expectations were that all meals be served on time. The DM stated meals being served late could cause the resident to not want to eat, and this could cause weight loss. The DM stated that the cook and herself are responsible to ensure meals are served on time. The DM stated this failure occurred due to difficulty in obtaining a safe temperature for all salads served for lunch meal. During a review of facility's grievance log on 09/04/2025 at 10:10 AM revealed a grievance on 07/25/2025 was filed due to lunch meal served at 1:00 PM and supper at 6:00 PM. Grievance filed on 06/16/2025 stated food is cold when served to residents. Grievance filed on 03/10/2025 stated meals are cold. During an interview on 09/04/2025 at 12:53 PM ADMN stated her expectations was that all meals be served at posted times. The ADMN stated meals not being served on time can affect quality of life. The ADMN stated it was the responsibility of the DM and cook to ensure meals were served on time. The ADMN stated the nurses and aides monitor for meals being served timely. The ADMN stated this failure occurred due to food temperatures not met for cold foods being served. The ADMN stated that department heads monitored meal service times randomly. Record review of facility's policy titled Frequency of Meals revised 10/2022 At least three daily meals will be provided, at regular times comparable to normal mealtimes in the community. The time between a substantial evening and breakfast the following day will not exceed 14 hours, except when a nourishing snack is served at bedtime. The Dining Service Director coordinates with the residents, administrator and/or Director of Nursing Services to establish the meal and snack times that are comparable with the normal times in the community. A schedule of meal service times will be provided to the nursing staff and available in the resident/patient care areas. The Dining Services (continued on next page)		

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: 455906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Lone Star Rehabilitation & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Senator Robert J Glasgow Loop Stephenville, TX 76401	
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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director will ensure that each meal is served withing the designated time frame unless there is an emergency situation or a resident request.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Lone Star Rehabilitation & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Senator Robert J Glasgow Loop Stephenville, TX 76401	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate residents' needs, preferences and accommodation of needs, for 1 (Resident #6) of 19 residents reviewed for dignity. The facility failed to ensure Resident #6's call light was within reach while he was in bed on 09/02/2025 and 09/03/2025. This failure could place residents at risk of a diminished quality of life and lead to a loss of self-esteem and isolation. Findings included: Review of Resident #6's face sheet dated 09/04/2025 revealed a [AGE] year-old male admitted on [DATE] with the following diagnosis: aphasia following cerebral infarction (difficulty speaking following a stroke), hemiplegia and hemiparesis following cerebral infarction affecting unspecified side (muscle weakness and inability to move muscles following stroke), and cerebral infarction (stroke). Review of Resident #6's quarterly MDS assessment dated [DATE] revealed: Resident #6 was rarely or never understood, and BIMS was not able to be performed. Section GG: Functional Abilities revealed Resident #6 had impaired range of motion to one side of upper extremities and had impaired range of motion on both sides of lower extremities. He was dependent on staff for bed mobility and helper did all the effort with bed to chair transfer. Section J: Health Conditions revealed Resident #6 had falls since admission with no injury. Review of Resident #6's most recent Care plan reviewed on 09/04/2025 revealed: Resident #6 has had an actual fall: 07/05/25 Fall, no injury 07/11/25 Fall, no injury Date Initiated: 07/07/2025 Revision on: 07/15/2025. During an observation on 09/02/2025 at 10:14 a.m., Resident #6 was lying in bed. He opened eyes to sounds but did not answer questions asked. He had a fall mat to the right of his bed. The call light was hanging on the wall behind and to the right of the head of his bed where the cable exits the wall. No staff were in his room. There were signs on two of the doors in Resident #6's room with message call, don't fall written on them. During an observation and interview on 09/03/2025 at 9:10 a.m., Resident #6 was lying in bed with a fall mat to the right of his bed. The call light was hanging on the wall behind and to the right of the head of his bed where the cable exits the wall. CNA A stated that the call light hanging on the wall was Resident #6's call light. She stated Resident #6 would not be able to reach the call light while it was hanging on the wall. She stated she did not know why the call light was not in Resident #6's reach. She stated she had been helping on another hall this morning and did not realize that the call light was hanging on Resident #6's wall. She stated not having call light in reach could cause Resident #6 to fall. During a telephone interview on 09/03/2025 at 2:26 p.m., Resident #6's representative stated Resident #6 was not able to get out of bed without help. During an interview on 09/03/2025 at 3:58 p.m., LVN B stated she was responsible for Resident #6. She stated Resident #6 could not exit his bed without assistance. She stated if Resident #6 was in bed and the call light was hanging on the wall where the cable exits the wall, Resident #6 would not be able to reach it. She stated all staff were responsible for making sure call lights were in the reach of the residents. She stated not having the call light in reach could interfere with residents being able to call for assistance. During an interview on 09/03/2025 at 4:07 p.m., the DON stated her expectation would be that call lights were in reach of residents when they were in bed. She stated that Resident #6 was not able to exit the bed to reach the call light if the call light was hanging on the cable where it exits the wall behind the head of his bed. She stated not having the call light in reach could interfere with residents calling for assistance. She stated the CNAs were responsible for call lights being in reach and the charge nurse was to monitor that call lights were in reach. During an interview on 09/04/2025 at 12:32 p.m., the ADMN stated it was her expectation that call lights were in reach of residents lying in bed. She stated Resident #6 could not get out of the bed safely to reach a call light if it was hanging on the wall behind the head of his bed. She stated Resident #6 would not use his call light and would yell out if he needed assistance but even so, she expected for him to have access to his call light. The ADMN stated the CNAs were responsible for making sure call lights were in residents' reach. She stated the charge nurses were who monitored (continued on next page)		

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: 455906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Lone Star Rehabilitation & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Senator Robert J Glasgow Loop Stephenville, TX 76401	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the CNAs were keeping call lights in reach. She stated the department heads rounded the halls daily during the week to monitor nursing staff. The ADMN added the department head that was assigned to the hall where Resident #6 resided was on vacation and could have led to failure of call light not being in reach. Review of facility document titled Strategies for Reducing the Risk of Falls revised on date December 2007 revealed: Transfer and Ambulation: Remind the resident and family to call as needed for assistance with transfer and ambulation.Room: call light within reach. Review of facility policy titled Answering the Call Light revised date March 2021 revealed: Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. Ask the resident to return the demonstration.When a resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.		