STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676077	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonewall Living Center	931 N Broadway Aspermont, TX 79502

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 residents (Resident #1) reviewed for accidents. The facility failed to ensure CNA A and CNA B implemented the appropriate amount of assistance when they transferred Resident #1 themselves instead of using a mechanical lift, as was care planned. The Failure resulted in staff having to assist Resident #1 to the flor, and required her to be sent to the hospital where she was ultimately diagnosed with a fractured right femur. The noncompliance was identified as PNC. The IJ began on 06/14/25 and ended on 6/17/25. The facility had corrected the noncompliance before the survey began This failure could place residents at risk for physical harm, pain, mental anguish, emotional distress and serious injury. Findings include: Record review of Resident #1's face sheet, dated 6/19/25, revealed a [AGE] year-old-female who was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], Resident #1 had diagnoses which included muscle weakness, difficulty walking and congestive heart failure (chronic heart condition) Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 13, which indicated the resident's cognition was intact. Section GG Functional Abilities did not indicate Resident #1 used a mechanical lift. Section V Care Area Assessment (CAA) Summary: CAA Results: 11. Falls (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Weight Summary, revealed the following: 6/02/25 202.2 lbs. Record review of Resident #1's progress notes, dated 3/19/25- 6/19/25, revealed: LVN C documented on 6/14/25 at 1:45 PM: Resident #1 was being transferred from her bed to the shower chair, and was lowered to the floor slowly by 2 CNA's (CNA A and B) and Family Member D at bedside. Provider E notified, and gave an order to send to hospital via transportation to ER for evaluation. The DON and Family Member D notified. LVN C documented on 6/14/25 at 2:39 PM: Notified EMS for transport-to-transport patient to ER for evaluation. LVN C documented on 6/14/25 at 2:40 PM: Transport called back and said they would have an ambulance come from a nearby city d/t unavailability of a backup ambulance. Resident #1 said she was ok and may just need some Tylenol, Tylenol administered as ordered. LVN C documented on 6/14/25 at 3:00 PM: LVN C asked if the Resident #1 was comfortable, Resident #1 was in bed and stated yes, she did not want to go to hospital and voiced concern to Family Member D that she wanted to stay at the facility, nurse encouraged patient that it was important to just go to the ER to get evaluated. Resident #1 agreed, Family Member D told patient she would go to the ER with her. LVN C documented on 6/14/25 at 3:18 PM: Called EMS to get an ETA on their arrival, dispatch stated they should be pulling up. LVN C documented on 6/14/25 at 3:28 PM: EMS got Resident #1 loaded into Ambulance and transported to the local hospital. LVN C documented on 6/14/25 at 4:18 PM: Nurse (Unknown) called from hospital and spoke with RN F and asked what exactly the patient was being sent over for observation for, nurse supervisor gave patient report. LVN C documented on 6/14/25 at 6:15 PM: RN F called the hospital and spoke with NP G and received results on Resident #1 that x ray and CT showed a Right Distal Femur FX, Family Member D and DON notified. LVN C documented on 6/15/25 at 6:10 PM: Resident #1 returned to the facility via EMS transport, Family Member D and Family Member H were with her, patient was smiling and stated she was so glad to be back in her bed. Brace/immobilizer to right LE in place. Resident #1 denied pain at this time. Provider E notified. Record review of Resident #1's care plan, dated 5/07/25, revealed: Focus: Resident #1 had an ADL self-care performance deficit r/t to CHF and weakness. (Initiated: 5/03/24 and revised 6/04/24) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goal: Resident #1 will maintain current level of function in ADL's. (Initiated 5/3/24 and Revised 11/11/24) Intervention(s): Transfer: Resident #1 required Mechanical lift with two staff assistance for transfers. (Initiated 8/21/24) Record review of Resident #1's incident report, dated 6/14/25, revealed Resident #1 was being transferred from her bed to the shower chair, and was lowered to the floor slowly by 2 CNAs (CNA A and CNA B) and Family Member D was at bedside. Provider E was notified and gave the order to send to the hospital via transportation to the ER for evaluation. The resident description revealed she had CNAs (CNA A and CNA B) on each side of her and her family member at bedside and the CNAs assisted to a standing position and after she stood with their assistance, her right leg started giving out on her and she told the aides she couldn't stand up no more and the CNAs assisted her to the floor softly. Resident #1 stated she did not have pain at the time. The immediate action taken was the CNA (specific CNA not identified) came to get the nurse (Specific nurse not identified). Nurse assessed Resident #1, took vitals and assessed for pain and discomfort (No additional details listed). Resident #1 was oriented to person, situation, place and time. No pain level was indicated. Record review of Family Member D's witness statement, dated 6/14/25, revealed two CNAs (unidentified in the statement) came to get Resident #1 up from her bed to go the shower. The CNAs were able to ger her (Resident #1) on the side of the bed to transfer her from the bedside to the shower chair. One CNA got on each side of Resident #1. Resident #1's legs began to fold under her. They (CNAs) lowered her to her knees, and they were unable to get her lifted, so they eased Resident #1 to her bum. Resident #1's right leg was bent under her to the side, but the staff were able to get it straightened out. The staff went to grab the mechanical lift to get her off the floor and into the shower chair. Record review of CNA B's witness statement, dated 6/14/25, revealed she and her partner (unidentified) went to transfer Resident #1 to the shower chair. When they realized they could not complete the transfer they set her (Resident #1) on the floor. She (CNA B) went to get the nurse while CNA A stayed with Resident #1. Record review of CNA A's witness statement, dated 6/14/25, revealed she and CNA B were transferring Resident #1 to the shower chair. Resident #1 started to pull down and they were unable to lift her (Resident #1) high enough to get her on the shower chair, so they lowered her (Resident #1) to her knees. Record review of Resident #1's medical record, dated 6/15/25 , revealed: Resident #1's reason for the visit was to address pain post fall. Imaging of the right lower extremity was conducted and revealed an acute traumatic fracture medial distal femur. There was no significant displacement. Resident #1 did not appear to be in any obvious distress. Resident #1 was pleasant and welled groomed. Record review of the facility's incident/accident report, dated 06/18/25, revealed Resident #1 had a witnessed fall on 06/14/25 at 1:30 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Form 3613 (Provider Investigation Report), dated 6/18/25, revealed CNA A and CNA B were the alleged perpetrators. Family Member D was a witness to the incident . Form 3613 indicated LVN C conducted an assessment on Resident #1. Form 3613 indicated the ADM was notified of the fall on 06/14/24 (Time not indicated) that involved Resident #1. CNA A and CNA B were preparing Resident #1 for a shower. The two CNAs performed a 2-person transfer. Resident #1 stood up and the right leg failed to support the weight of Resident #1. Resident #1 was guided to the floor by CNA A and CNA B. Resident #1 complained of knee pain. CNAs (CNA A and CNA B) alerted charge nurse about the incident. The DON interviewed both CNAs (CNA A and CNA B). There was no reason given by either CNA why they chose not to follow the care indicator instructions. Care indicators were posted and had been in-serviced to staff. The DON suspended both CNAs immediately pending the outcome of the investigation. Record review of the facility's admission discharge report, dated 6/23/25, revealed Resident #1 discharged from the facility on 06/14/25 and returned to the facility on [DATE]. An observation was made on 06/18/25 at 3:01 PM of two pictures next to her room name plate of a mechanical lift and a picture of two people. During an interview on 06/18/25 at 3:01 PM, Resident #1 stated she fractured her leg. She stated she was the only one in the room when it happened. She stated she sat up on the side of the bed and when she stood up her legs gave out. She stated no one was in the room with her. She denied CNA A and CNA B being in the room with her. She denied Family member D being in the room with her. She stated she was all alone. She could not recollect the time when the fall occurred and stated she could not remember how she got off the floor and who helped her. She stated the staff used the mechanical lift but there was a time when she could help staff transfer herself, but she was too weak to do it on her own. She stated she felt safe at the facility and did not have any concerns. She stated she was not in pain at the time of the interview and if she was in pain she could get pain medication if she wanted it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/18/25 at 10:53 AM the ADM stated regarding Resident #1 and her fall it was reported to her that the staff (unspecified) was getting Resident #1 ready for her shower. She stated that her initial report to state was that the incident occurred in the shower room but later confirmed that the incident took place in Resident #1's room. She Resident #1 was sent to the hospital and came back the next day with a small fracture. She stated she suspended both CNAs. At the time of the interview, she did not have the CNAs name but stated the DON would know their names. She stated during her investigation she identified Resident #1 was supposed to have the mechanical lift for transfers. She stated the DON conducted the interviews and would defer to her for what was said in those interviews. She stated she was familiar with the facility policy on using the correct lift for the residents. She stated the system to monitor staff and resident transfers was they had icons (pictures) on the outside of each resident's door that required a specialized transfer. She stated nursing staff will round and ensure that the CNAs are using the appropriate transfer. She stated that there is cheat sheet or care indicator form that is kept at the nurses' station and it also has pertinent information about each resident to include their appropriate transfer. She stated this system was in place at the time that the CNAs transferred Resident #1. She stated the purpose of conducting appropriate transfers was for resident and staff safety. She stated the potential negative outcome if the improper transfer was used was injury to the staff and residents. She stated she or the DON was unaware that CNAs were using the incorrect transfer for Resident #1. The ADM stated she had been trained regarding using the appropriate lift for residents and her staff had also been trained. She stated she expected her staff to use the appropriate transfer for each resident when providing care. She stated the staff should be following the resident's care plan. The ADM stated the staff are responsible for the care that they provide and are responsible for using the appropriate transfer for the resident's which should prevent incidents and accidents. She stated there was no reason that was given to her as to why the CNAs used the inappropriate transfer when transferring Resident #1 on 06/14/25. The ADM stated because of the incident involving Resident #1 the staff were immediately inserviced on ANE, care indicators, and following the resident's care plan. The ADM stated CNA A and CNA B have not worked since the date (6/14/25) that they used the incorrect transfer. She stated CNA A would be terminated and CNA B who worked for the temporary staffing agency would be placed on a list that indicated that she could no longer work at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/18/25 at 10:54 AM the DON stated regarding Resident #1 her care indicators that show staff what transfer to use is posted outside the door and have been even on 6/14/25 when CNA A and CNA B performed the incorrect transfer on Resident #1. She stated on 06/14/25 Family Member D was in the room when the incident occurred. She stated a discussion was had regarding getting Resident #1 up for a shower. She stated CNA A and CNA B conducted a two person transfer and during the transfer Resident #2 stated one of her legs gave out and both CNAs assisted Resident #1 down to the floor. She stated Resident #2 complained of pain and the nurse (unspecified at this time) conducted an assessment. She stated Resident #2 was transferred to the hospital for further evaluation. The DON stated after consultation with orthopedics it was determined that Resident #2 was not a candidate for surgery and would return to the facility with an immobilizer. The DON stated her diagnosis given was a mildly displaced femur fracture. The DON stated she spoke with Family Member D, and she (Family Member D) stated she had instructed the CNAs to give Resident #1 a shower. She stated Family Member D did not instruct the CNAs which transfer to use. The DON stated she was familiar with the facility policy regarding safe transfers and incident and accident prevention. She stated the purpose of having and following the facility policy was to prevent injury to staff and residents. She stated failure to follow the policy could cause injury to the staff or residents. She stated she was unaware at the time of the incident that CNA A and CNA B were performing the incorrect transfer but was made aware when the charge nurse reported the incident to her. The DON stated she knew automatically that the wrong transfer was used because she knew Resident #1 and knew that the mechanical lift should have been used. She stated they had a total of three mechanical lifts, and all are operational. She stated the system to monitor that staff were using the appropriate transfer was through staff training. She stated training occurred upon hire and annually. The DON stated she had been trained on the use of appropriate transfers and all her staff had also been trained on using the proper transfer for residents in the facility. She stated she had provided the staff inservice training on ANE (preventing abuse), the care indicators (located on the outside of the door), where to find the information regarding resident transfers and the importance of using the appropriate transfer for each resident. She stated the care indicator system located outside of the door was in place at the time CNA A and CNA B transferred Resident #1 on 6/14/25. She stated they had trained all staff that had worked since the incident. She stated that she expected all her staff to use the appropriate transfer for each resident to prevent incidents and accidents. She stated when she interviewed CNA A and CNA B there was no reason given why the incorrect transfer was used. She stated Resident #1 used the mechanical lift because she is bed and wheelchair bound. She stated Resident #2's transfer was already in place. She stated physical therapy did not evaluate her recently for her transfer, but that Resident #1 has always used the mechanical lift. She stated that Resident #1 had used the mechanical lift for a long time. Interviews conducted on 6/18/25 between 1:32 PM-1:44 PM, revealed that staff (CNA W, NA X) had been trained on the use of mechanical lift and appropriate transfers for residents. They stated the mechanical lifts at the facility are operational. They were able to report that there was never a reason they would use an inappropriate transfer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an Interview on 06/18/25 at 1:58 AM CNA A stated that she had been trained on the facility's system for appropriate transfers for residents. She stated she had been trained on the use of the mechanical lift. She stated that she was trained that there was never a reason that she should deviate from the appropriate transfer for any resident. She stated she received the training before 6/14/25 when the incident that occurred on 6/14/25 involving Resident #1 being lowered to the floor after she and CNA B had used the incorrect transfer. She stated on 06/14/25 she was instructed by RN F to shower Resident #1 and to get someone to help her. She stated he got CNA B to help her. She and CNA B were transferring Resident #1 into the shower chair. CNA A stated she did not look at the pictures/icons on the outside of the door when she first went in. She stated when they attempted the 2-person transfer Resident #1 dropped her weight. She stated she and CNA B had to sit Resident #1 down on her knees. She stated they continued and lowered her slowly down on her butt. She stated that once they got Resident #1 down the pulled her legs gently out from under her. She stated Family member D was present in the room. She stated Family Member D did not stop them or instruct them to do the 2 person transfer on Resident #1. She stated she or CNA B did not realize that Resident #1 used the mechanical lift. She stated Resident #1 usually receives her shower at night. CNA A stated she normally would look at the resident door before she transferred a resident but in the case with Resident #1, she did not. She stated when Resident firs was admitted she did not use the mechanical lift, but it had been a long time since she had worked directly with Resident #1. CNA A stated she could not give the exact time she and CNA B conducted the transfer but that she did not uses a mechanical lift. CNA A stated Resident #1 did not necessarily fall in her opinion because she and CNA B sat her down on her bottom very slowly. CNA A stated they did not sit her down hard. She stated that Resident #1 was not in pain but later complained of pain in her leg. She stated she could not be for sure, but it may have been 5 minutes or so after the incident. She stated they got the nurse. She stated LVN C and RN F came in. She stated they were told at that time that Resident #1 was supposed to use the mechanical lift. She stated from that point they used the mechanical lift to get Resident #1 from the floor, shower and returned her to bed. She stated Resident #1 had to get x-rays because she was in pain. She stated she did not work any additional shifts because she was suspended pending investigation. She stated the potential negative outcome of not using the appropriate transfer was the residents could get injured or receive a fractured bone. She stated they ran the risk of dropping Resident #1 or pulling her limbs too hard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/18/25 at 2:25 PM CNA B stated that she had been trained on the facility's system for appropriate transfers for residents. She stated she had been trained on the use of the mechanical lift. She stated that she was trained that there was never a reason that she should deviate from the appropriate transfer for any resident. She stated she received the training before 6/14/25 when the incident that occurred on 6/14/25 involving Resident #1 being lowered to the floor after she and another cna (unspecified during the interview) had used the incorrect transfer. She stated she had used a 2 person transfer with Resident #1 before with another staff that she could not remember her name. She explained it was a long time ago but could not be sure of the period. CNA B stated on 6/14/25 the shower girl asked if she (CNA B) could help her transfer Resident #1. She stated she did not know the other can's name. CNA B stated it was her mistake for not checking the door before she went into Resident #2's room. CNA B stated she did not realize Resident #1 used the mechanical lift. She stated Family Member D was in the room when they conducted the transfer. CNA B stated when they conducted the two-person transfer Resident #1's right leg gave out from under her, and they had to sit Resident #1 down slowly. CNA B stated Resident #1 did not go down hard. She stated they pulled her right leg out from under her gently. She stated that Family Member D was in the room with them and did not stop them from conducting the two person transfer but Family Member D did not instruct them to do the 2-person transfer either. She stated Resident #1 was a larger resident and that was how they knew to at least have 2 people. She stated she was in a hurry on 6/14/25 and she thought that it would be like every other time she had ever conducted a 2-person transfer on a resident. She stated Resident #2 does not typically shower during the day, but Family Member D requested that Resident #1 be showered during the day. CNA B stated she was fully aware of the icons/pictures on the outside of the door, and she should have looked for them. She stated when the incident happened, she left to get a nurse and left the other cna with Resident #2. She stated that she grabbed a sling on the way back. She stated once Resident #2 was assessed they got her up using the mechanical lift. She stated they proceeded to take her to the shower. She stated Resident #1 did not complain of pain. She stated she later heard after the incident complained of pain but was not present. She stated that she was suspended pending the investigation and has not worked a shift since the incident on 6/14/25. She stated she had a shift scheduled after, but it was cancelled. During an interview on 6/18/25 at 3:16 PM Resident #3 stated there were no additional concerns with resident transfers or failure to use the mechanical lift when appropriate. She stated there was always two staff that used the mechanical lift when they transferred her. She stated no had ever tried to use any other transfer on her while she has resided at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/18/25 at 7:00 PM Family Member D stated that she was present in the room when the two aides transferred Resident #1. She stated she did not know the two aides' names. Family Member D stated that she had asked that Resident #1 have a shower. She stated the two aides did 2-person stand pivot. She stated that Resident right leg gave out and the two aides lowered Resident #1 to the floor. She stated they lowered Resident #1 very slowly but that they lowered her on top of her knee first and then to her bottom. She stated that the aide pulled her right leg out from under her. She stated the aides were gentle with Resident #1. She stated that Resident did report her knee hurt but was not complaining really bad. She stated that she had never observed any staff do a 2-person transfer with Resident #1 before. She stated she had always observed staff use the mechanical lift. Family Member D stated that she should have stopped them, but she thought that about how it would make her feel if someone came to her place of work and told her how to do her job. She stated that she did not have any complaints about the facility, and they take really good care of Resident #1. She stated Resident #1 sometimes does get confused and she (Family Member D) was not surprised that Resident #1 did not fully remember what happened. She stated the same day when they went to the hospital on [DATE] Resident #1 could not give a full of count of what happened, and she (Family Member D) had to assist in telling the doctors what happened. During an interview on 6/18/25 at 5:15 PM The DON stated she would provide updated inservices on 06/19/25. She confirmed that all staff on leave, PRN, and agency would be inserviced prior to being able to work their shift. During interviews conducted on 06/19/25 from 10:56 AM-11:40 AM, staff that worked the day time shift (LVN I, LVN L, LVN O CNA K,CNA M, CNA N, CNA P, CNA Q, CNA R, CNA Y, CNA Z) were able to report that that since 6/14/25 they had been trained/reeducated on the facility's abuse policy. They stated they had been trained that ANE not only included reporting but prevention. They were able to report that using the proper transfer for residents was a way to prevent incidents, accidents, and neglect. They were able to report that they would never use an inappropriate transfer for a resident. They were able to report that they had been trained/reeducated on the facility system on the posted icons/pictures outside of the resident's door. They stated even if they had provided care to a resident in the past they would check the door, care indicator sheet at the nurse's station, care plan and or ask a charge nurse for clarification. They all stated they felt comfortable and confident in their role regarding resident transfers, ANE policy, and preventing incident and accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/19/25 at 2:15 PM RN F stated she worked on 6/14/25 at the facility. She stated that she could not remember the two cna's names, but that Family Member D requested that Resident #1 be showered. She stated she instructed the aides to shower her. RN F stated she was not in the room when the aides transferred her. She stated she was told by staff (not specified) that the aides did a 2-person transfer to place Resident #2 in the shower and Resident #2's leg buckled under her. The aides eased Resident #1 to the floor. Resident #1's right leg was under her, and the aides pulled her leg out. Family Member D reported to her that Resident #1 was fine. She stated Resident #1 was assessed and reported to be fine and not in any pain. She stated after Resident #1 took her shower and was placed bed with the mechanical lift that was when the resident complained of pain. RN F stated the pain was not tremendous. RN F stated Resident #1 did not initially want to go to the hospital but after encouraging from staff and Family Member D she agreed to go. Once Resident #1 made it to the hospital that was when they received the x-ray that Resident #1 had a fracture. RN F stated Resident #1 received Tylenol while she waited for EMS transport. RN F stated she was not told why the aides did not use the mechanical lift and they may have told LVN C. RN F stated the signs of the appropriate transfer is posted outside of the residents' room and was posted outside of Resident #2's room on 6/14/25. During an interview on 6/19/25 at 2:21 PM LVN C stated she was not in the room when CNA A and CNA B transferred Resident #1 on 6/14/25 but that she was the nurse in charge of Resident #1 on that day. She stated when the transfer happened one of the cna's came to get her, but she could not remember which one. She stated she was told that they did a 2-person transfer on Resident #1 and when they stood Resident #1 up to pivot with her, her right leg gave out. She stated the staff reported to her that they lowered her to the floor. She stated as soon as she (LVN C) was notified she ran in there and started her assessment. She stated she immediately explained to the aides that Resident #2 required the mechanical lift. She stated she asked the aides if they saw the sign on Resident #2's door. She stated before they could answer Family Member D interjected, apologized and explained that she was the one who told them to get Resident #1 up. LVN C stated she explained to Family Member D that it was not her fault, and the staff knew what they were supposed to do. LVN C stated she knew that both aides knew to check the door and knew where to go check for transfer information because they had worked at the facility even before she started. She stated Resident #1 did not want to go to the hospital, but they encouraged her. She stated Family Member D convinced Resident #1 to go. She stated she assessed Resident #1 and there were no concerns. She stated she administered Tylenol to Resident #1 but Resident #1 did not complain of excruciating pain. During an interview on 6/19/25 at 3:52 PM CNA M stated she had been trained how to use the mechanical lift. She stated all mechanical lifts (x3) were operational. She was able to describe how she would use the mechanical lift to include ensuring that the wheels are locked during the ascending and descending process. She stated that the mechanical lift was not used for transport but only for transfer. She stated that before she would use the mechanical lift she would inspect the machine to include the sling and that they only use the mechanical lift with two staff at all times. During an interview on 6/19/25 at 3:55 PM CNA K stated she had been trained how to use the mechanical lift. She stated all mechanical lifts (x3) were operational. She was able to describe how she would use the mechanical lift to include ensuring that the wheels are locked during the ascending and descending process. She stated that the mechanical lift was not used for transport but only for transfer. She stated that before she would use the mechanical lift she would inspect the machine to include the sling and that they only use the mechanical lift with two staff at all times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676077	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonewall Living Center	931 N Broadway Aspermont, TX 79502

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CNA A's course completion report, dated 6/18/25, revealed CNA A completed Fall Prevention for Older Adults on 08/7/24. CNA A completed preventing, identifying, and responding to abuse and neglect on 08/11/24. Record review of CNA B's Required credentials, dated 6/18/25, revealed that her abuse, neglect and exploitation was valid and did not expire until December of 2025. Record review of the CNA B's Acute CNA Assessment, undated, revealed CNA B passed the assessment with the required 70 or above. Patient Safety and Patient Mobility and transfers were areas covered in the assessment. Record review of the facility's inservice sheet, dated 6/10/25 revealed 30 staff had been inserviced on the facility's fall policy and ANE policy. Record review of the facility's inservice sheet, dated 6/14/25 revealed 26 staff had been inserviced on the facility's care indicators system located on the resident's doors, Patient centered care, ANE policy and Resident lifting. Record review of the facility's care indicator legend, undated, revealed 8 pictures and the corresponding indicator to include whether a person was a high fall risk, 2 person assist, 2 person transfer and mechanical lift. Record review of the Resident Care Guide, undated, revealed Resident #1 was on hall 2 and required a mechanical lift with 2 people. Record review of the facility's policy, Assessing Falls and Their Causes, Revised March 2018, revealed: Purpose: The purpose of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Record review of the facility policy, Safety and Supervision of Residents, Revised December 2007, revealed: Policy: Our facility strives to make the environment as free from accident hazards as possible. Residents' safety and supervision and assistance to prevent accidents are facility wide priorities. Resident-Oriented Approach to Safety: Staff shall use various sources to identify risk factors for residents, including the information obtained from medical history, physical exam, observation of the resident, and the MDS. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accidents hazards or risk for that resident. The care team shall target interventions to reduce the potential for accidents. Implementing interventions to reduce accident risks and hazards shall include the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assigning responsibility for carrying out interventions. Providing Necessary training Ensuring that interventions are implemented Monitoring the effectiveness of interventions shall include the following: Ensuring the interventions are implemented correctly and consistently Resident Risks and Environmental Hazards: Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated [TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 7 residents (Resident #2) reviewed for medication. The facility failed to prevent Resident #2's Methocarbamol 500 MG medication from being accounted for, between April 2025-June 2025. This failure could place residents at risk for not receiving prescribed medication for specified diagnosis. Findings include: Record review of Resident #2's face sheet, dated 6/19/25, revealed a [AGE] year-old-female who was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident #2 had diagnoses which included dementia (memory loss) and pain in left knee. Record review of Resident #2's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 15, which indicated the resident's cognition was cognitively intact. Section I Active Diagnosis: Pain in Left Knee Section J Health Conditions: Resident #2 was on a pain medication regimen, received PRN pain medications. Section V CAA did not reveal Resident #2 should be care planned for pain. Record review of Resident #2's Order Summary Report, dated 6/19/25, revealed: Methocarbamol Oral Tablet 500 mg (1 tablet by mouth every 8 hours as needed for muscle pain/spasms related to low back pain (Ordered and Started 9/12/24) Record review of Resident #2's MAR for March 2025 revealed: Methocarbamol 500 mg was administered a total 8 times (three times on 3/14, 3/15, 3/17, 3/26, 3/30 and 4/31) Record review of Resident #2's MAR for April 2025 revealed: Methocarbamol 500 mg was administered a total 6 times (4/1, 4/14, 4/16, 4/22, 4/23, and twice on 4/24 Record review of Resident #2's MAR for May 2025 revealed: Methocarbamol 500 mg was administered a total 3 times (5/1, 5/2, and 5/24) Record review of Resident #2's MAR for June 2025 revealed: Methocarbamol 500 mg was administered a total 2 times (6/4 and 6/15) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan, dated 3/31/25, revealed: Focus: Resident #2 is on pain medication therapy r/t low back pain. (Initiated 9/16/24 and revised on 10/4/24) Goal: Resident #2 will be free of any discomfort or adverse side effects from pain medication. (Initiated 9/23/24 and revised 1/6/25) Intervention(s): Monitor/Document/Report PRN adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, and urinary retention. Record review of the facility's Form 3613 (Provider Investigation Report), dates 6/11/25, revealed on 06/05/25 the DON was notified of an inconsistent medication count on Resident #2's 500 MG Methocarbamol. The inconsistent count was noted as order too early. The DON conducted an investigation regarding count and re-order request. It was determined 23 pills were not accounted for. The DON contacted the nurses (not specified). The DON reviewed/ in-serviced on medication administration and documentation protocols. Nurses acknowledged the in-service. The DON requested the pharmacy to replace the medication, and bill was charged to the facility. The DON noted the resident did not experience any negative impact. The DON initiated muscle relaxers should be counted along with the controlled medications. Record review of the facility pharmacy orders, dated 3/4/25, revealed Resident #2's 500 MG Methocarbamol was ordered. Record review of the facility pharmacy orders, dated 4/15/25, revealed Resident #2's 500 MG Methocarbamol was ordered. Record review of the facility pharmacy orders, dated 4/29/25, revealed Resident #2's 500 MG Methocarbamol was ordered. Record review of the facility pharmacy orders, dated 5/27/25, revealed Resident #2's 500 MG Methocarbamol was ordered. Record review of the facility's pharmacy sheet, dated 3/04/25, revealed Resident #2 received a medication card that included 30 500 MG Methocarbamol on 03/03/25. Record review of the facility's pharmacy sheet, dated 4/15/25, revealed Resident #2 received a medication card that included 30 500 MG Methocarbamol on 4/15/25. Record review of the facility's pharmacy sheet, dated 4/30/25, revealed Resident #2 received a medication card that included 30 500 MG Methocarbamol on 4/30/25. Record review of the facility's pharmacy sheet, dated 6/05/25, revealed Resident #2 received a medication card that included 30 500 MG Methocarbamol on 06/05/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was made of the medication administration card (Methocarbamol Oral Tablet 500 mg) and the Medication Count sheet. The Medication Administration card and count sheet were accurate reflecting 3 pills in one card and on the corresponding sheet and 30 pills in the second card and on the corresponding count sheet. During an interview with Resident #2 on 06/18/25 at 3:20 PM, she stated she received her medications when prescribed. She stated she did not know the exact names of the medications, but she received them when she asked for them. She stated there had never been a time where she was in pain, asked for medication and it was unavailable. She stated she mostly had pain in her knees. She stated she was unaware if she had any missing medications. During an interview on 6/18/25 at 10:53 AM, the ADM stated regarding Resident #2's missing muscle relaxer they (ADM and DON) were alerted by the Pharmacy Consultant it was too early to order Resident #2's muscle relaxer. She stated it was reported to her by the DON there were 23 missing muscle relaxers that had not been accounted for. She stated the facility paid for the replacement. She stated during her investigation she found there was no uncontrolled pain or needs not met for Resident #2. She stated she determined this through record review and interviewing Resident #2. She stated Resident #2 still had medication if she needed a dose. She stated a full cart count was conducted. She stated because of the incident they decided to place the muscle relaxers on a count sheet like the controlled medication to alleviate future errors. She stated she did not have a date of when the medication would have come up missing because as a rule, they did not count muscle relaxers. She stated in her PIR she determined the incident involving Resident #2 and her missing medications unfounded because it was determined to be a documentation error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/18/25 at 10:54 AM, the DON stated Resident #2 was the only resident in the facility on muscle relaxers. She stated during her investigation of the missing documentation it was determined the muscle relaxers were not missing and it was a documentation error. She stated she would now conduct administration checks of the medication. The DON stated she was now placing the muscle relaxers on a count sheet like the narcotic medications. She sated because the muscle relaxers were not counted the error was not caught. She stated they were alerted to inconsistencies because the Pharmacy Consultant stated when the medication was reordered it was told to them it was too early to re-order. The DON stated she found there was a discrepancy in what was in the EMR and what was documented. She stated there was at least four times documented the medication was refilled, and it did not coincide with the EMR. She stated without the medication being signed out it would be difficult to determine what was missing. She stated before the muscle relaxer would have been stored on the medication cart. She stated the nurses were the only ones who gave medications and had access to the medications for residents. She stated the night nurses were the nurses who reordered the medication. She stated the night nurse was trained if the medication had 7 or less medication that it was time to reorder the medication. She stated when the night nurse reordered it was a routine order. She stated she determined 23 muscle relaxers were missing because the last refill was made on 4/30 for a total of 30 pills. She stated when she looked at the EMR only 3 doses were charted. She stated this would have left 23 doses not documented. She stated there would have been 4 or 5 pills still left on the card. She stated at least 3-4 times a week she checked the narcotics and checked the muscle relaxers for Resident #2. The DON stated she did not think anyone took the medications or there was a drug diversion because there were no missing controlled medications. The DON stated she felt it was a documentation error. She stated she believed the medication was being administered but not documented . She stated when she interviewed the nurses they stated in general they sometimes forgot to document when they administered PRN medications. She stated all nurses were placed on a PIP . She stated she did not have any written statements from any of the nurses she interviewed. She stated she did not identify any inconsistencies overall in PRN medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/18/25 at 2:41 PM, the Pharmacy Consultant stated the day after Memorial Day the facility staff (unspecified) requested a refill on Resident #2's muscle relaxers (Methocarbamol 500 MG). She stated a part of the routine with PRN medications she would check to see if the resident was taking the medication regularly to see if they needed to refer the resident to the physician. The Pharmacy Consultant stated she did not fill the requested medication because it was too early. She stated it was reported Resident #2 had 5 pills on site. The Pharmacy Consultant stated when she checked Resident #2's EMR she had only seen 3-4 pills were administered. The Pharmacy Consultant stated as a rule narcotics were the only medication that would be counted. She stated she suggested to the facility that the muscle relaxers be locked up and accounted for. She stated she emailed the facility Resident #2's MAR that she reviewed and contacted the ADM and the DON about the medication. She stated Resident #2 was not consistent in taking the PRN muscle relaxer. She stated she could not be sure without the paperwork in front of her but the medication was ordered at least three times between the end of May and June. She stated without counting the medication it could not have been prevented but in the past before the new management team they counted muscle relaxers but with the new management team they no longer counted muscle relaxers. She stated she was unaware why this had changed. She stated she felt an audit needed to be conducted by someone other than the facility staff. The Pharmacy Consultant stated the Monday after she identified the problem she went to the facility and offered and was prepared to conduct an audit but was told by the DON it was her (DON) job to conduct an audit . The Pharmacy Consultant stated this disturbed her. The Pharmacy Consultant stated she did not look at any of the controlled medications sheets. She stated without being able to conduct and audit it would be difficult to get an accurate number. She stated if the facility stated there were 23 pills unaccounted for that would lead her to believe the medication were taken. She stated 23 missing pills was a lot for a documentation error . During an interview on 06/19/25 at 10:56 AM, LVN I stated she was a nurse at the facility. She stated nurses were the only staff to administer medications. She stated she did not have any information about any missing muscle relaxers, but it was reported to her the muscle relaxers were not being documented when they were administered. She stated as a result of this error they now must count the muscle relaxers like they did the narcotics. She stated before they did not count muscle relaxers. She stated in the past she administered the muscle relaxer to Resident #2, but never forgot to document the medication. She stated Resident #2 typically would receive her muscle relaxer in the evening. She stated she heard through staff talking there were 23 of the muscle relaxers not documented. She stated Resident #2 was the only resident in the facility who took muscle relaxers. During an interview on 6/19/25 at 11:21 AM, LVN L stated she was a nurse at the facility. She stated nurses were the only staff to administered medications. She stated she did not have any information regarding the muscle relaxers that were unaccounted for. She stated she heard about it here and there. She stated she was surprised when she worked and saw the muscle relaxers were in the locked box with the narcotics. She stated they normally did not keep them there and did not count them. She stated because she worked at night she did the ordering of medications. She stated she heard the Pharmacy Consultant stated the medication was ordered before it should have been. She stated she heard about it when she came to work one night. She was unsure of the exact date and time and who notified her. She stated she was not necessarily questioned about it but was told the medication was not being documented. She stated she never administered the medication to Resident #2. She stated the only reason she ordered the medication was because it was low. She stated she was trained to order the medication when medications got down to 7 or 8 pills. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/19/25 at 11:57 AM, LVN O stated she was a nurse at the facility. She stated nurses were the only staff to administered medications. She stated she did not have any information regarding Resident #2's muscle relaxers that were not accounted for. She stated she did not work with Resident #2. She stated she had never administered any muscle relaxers to Resident #2. She stated no one on her hall took muscle relaxers. During an interview on 6/19/25 at 12:26 PM, LVN S stated she was a nurse at the facility. She stated nurses were the only staff to administered medications. She stated she did not have any firsthand information on Resident #2's muscle relaxers. She stated she normally worked the opposite hall Resident #2 resided and never administered any muscle relaxers to Resident #2. She stated because of the documentation error with Resident #2, they were told they would have to count muscle relaxers, but this did not apply to her since no one on her hall took muscle relaxers. She stated she was not questioned about the muscle relaxers but heard about it in passing. During an interview on 6/19/25 at 12:42 PM, LVN T stated she was a nurse at the facility. She stated nurses were the only staff to administer medications, but she never administered medications at the facility. She stated she only consulted with the staff for MDS purposes. During an interview on 6/19/25 at 12:48 PM, LVN BB stated she was a nurse at the facility and was PRN. She stated nurses were the only staff to administer medications at the facility. LVN BB stated she had only been to the facility twice. She stated the last time she worked at the facility would have been the previous Thursday (6/12/25). She stated she knew muscle relaxers were now in the lock box with the narcotics. She stated they received an in-service as to why they were locked up. She stated she was told the medications were not being locked up. She stated she did not know how the facility determined the situation was a documentation error, but she had administer the medication. She stated the DON went over the in-service with her. During an interview on 6/19/25 at 12:54 PM, LVN CC stated she was a nurse at the facility. She stated nurses were the only staff to administer medications. She stated she did not administer medications but she only was available if there were concerns regarding the MDS. During an interview on 6/19/25 at 1:00 PM, RN U stated she was a nurse at the facility. She stated nurses were the only staff to administer medications. She stated she administered medications at the facility but never administered any PRN muscle relaxers to Resident #2. She stated if she had administered the medication, she would have documented it. She sated as a result Resident #2's undocumented PRN medication, they now had count the muscle relaxers. She stated it was told to her in passing the issue was not being documented. During an interview on 6/19/25 at 1:02 PM, RN V stated she was a nurse at the facility. She stated nurses were the only staff to administer medications. She stated she received an in-service about ensuring all PRN medications were documented. She stated she provided care to Resident #2 the previous Tuesday (6/17/25) and she did not administer any PRN muscle relaxers to her. She stated she never administered any PRN muscle relaxers to Resident #2. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/19/25 at 2:15 PM, RN F stated she was a nurse at the facility. She stated nurses were the only staff to administer medications at the facility. She stated she did not have any firsthand information regarding Resident #2's PRN muscle relaxers. She stated she rarely administered medications. She stated she would assist if needed. She stated she provided supervision and observation of staff and residents when she was on shift. She stated she was uncertain if the medication was taken from the facility or if there was an issue with documentation. During an interview on 6/19/25 at 2:21 PM, LVN C stated she was a nurse at the facility. She stated nurses were the only staff to administer medications. She stated she did not have any firsthand knowledge regarding Resident #2's muscle relaxers. She stated Resident #2 did go home sometimes. She stated the medications went home with her. She stated Resident #2 went home for Easter, Mother's Day weekend and around graduation time . She stated they do count Resident #2 medications such as narcotics but never the muscle relaxers. She stated she never noticed a significant amount of the muscle relaxers gone when she returned from being on pass with her family. LVN C stated she administered the PRN medication to Resident #2 but stated she documented every time. She stated she never administered the medication and did not document. She stated she administered at least 2 PRN doses since the medication was moved to the lock box. She stated prior to the undocumented PRN muscle relaxers they never counted the muscle relaxers but now they must count them along with the narcotics. She stated there were no other residents who took muscle relaxers. During an interview on 6/19/25 at 2:35 PM, Family Member DD stated she was notified by the facility staff Resident #2's medication was off. She stated she was not for sure which medication. She stated when Resident #2 went home on pass the facility gave her Resident #2's medication. She stated if it were prescribed, she would administer the medication. She stated Resident #2 only came home once a month and it would only be for three days at a time because the facility policy only allowed her to be out of the facility for 72 hours at a time. She stated there was one month Resident #2 went home with her twice in one month. She stated even at the rate of coming once a month and recently two times in one month she would not have administered any medication 23 times. She stated when she was sent home with medications the nurses would count the medications before she left and when she came back. She stated she never had an instance when any medication counts were not accurate. She stated she hoped the medications were not taken. She stated she trusted the facility staff and they took excellent care of Resident #2. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/19/25 at 3:31 PM, the ADM stated it was the facility's responsibility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. She stated she was familiar with the facility's pharmacy program and their policies. She stated if medication was missing or accounted for this could place the resident at risk of not having the medication available placing the resident at risk for uncontrolled pain. The ADM stated nothing was 100 percent and she could not say if there was a documentation error or if the medications was taken. The ADM stated the nurses who were interviewed admitted they failed to document PRN medications but not specifically regarding Resident #2. The ADM stated she was not aware about 23 undocumented muscle relaxers until the Pharmacy Consultant notified them. She stated the system the facility used to monitor resident medication was the DON and management team verified the medication and documentation matched. She stated this was discussed daily if there was an issue. She stated she was trained on the facility's pharmacy services. She stated she expected resident medication to be administered and documented appropriately. She stated the DON was responsible for the facility pharmacy and pharmaceutical services. She stated the reason the muscle relaxers were not accounted for was there was a system failure in documentation on the facility nurse's behalf. During an interview on 6/19/25 at 3:37 PM, the DON stated it was the facility's responsibility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. She stated she was familiar with the facility's pharmacy program and their policies. She stated if the medication was missing or unaccounted for there was a risk the medication would be unavailable for the resident. She stated the potential negative outcome was the resident could be in pain. The DON stated she could not 100 percent prove the medication was not taken but she did have evidence to support it was a documentation error with other residents but not with Resident #2. She stated documenting PRN medications was an issue with her nurses since December 2024 . She stated she had been addressing the issue with her nurses through in-services. The DON stated no nurses specifically admitted they failed to document Resident #2's PRN muscle relaxer. She stated she was unaware there were 23 muscle relaxers unaccounted for until the Pharmacy Consultant brought it to her attention and ever since she started counting them with the narcotics. She stated she was trained regarding the facility's pharmacy services. She stated she expected for resident medications to be administered appropriately per policy and documented. She stated if there was a way to account for the medication then staff should be making sure the medication was accounted for. She stated she was responsible for the facility pharmacy service program in the facility. She stated she did not have a reason as to why the PRN muscle relaxers for Resident #2 were not accounted for. She stated there was no chance Resident #2's PRN muscle relaxers could have been given to another resident as there were no other residents in the facility who took muscle relaxers. During an interview on 6/23/25, the Pharmacy Consultant stated the facility received the refills (30 pills) of the Methocarbamol on 3/03/25, 5/15/25, 4/30/25 and 6/05/25. She stated she had signature logs that were faxed back to the pharmacy, and she would send those to the state surveyor (They were not sent). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676077	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonewall Living Center	931 N Broadway Aspermont, TX 79502

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 6/24/25 at 8:51 AM, she stated the 23 missing/undocumented muscle relaxers came from the Pharmacy Consultant when she identified the inconsistency between Resident #2's medical record. She stated she did not look at the past 90 days of the medication refill orders. She stated it appeared all ordered was received. She stated the muscle relaxers that were ordered ere received on 3/03/25, 4/15/25, 4/30/25, and on 06/05/25 and they were signed for by LVN L . She stated now she would be the staff who would retrieve the facility's medication order from the pharmacist when it was ready. She stated the medication was administered 8 times in March, 6 times in April, 3 times in May and 2 times in June as the muscle relaxer was a PRN medication and was only given when requested. She stated she was unaware the total of undocumented/missing medications was 71 not 23. She stated she understood how the state surveyor could come up with that number by taking the total amount of muscle relaxer refills from March 2025-April 2025 (90 500 MG Methocarbamol) and subtracting the total amount administered according to Resident #2's MARs from March 2025-June 2025 (19 500 MG Methocarbamol) equaling 71 pills not accounted for. She stated she still believed it was a documentation error and the pills were given and not documented. She stated when she interviewed Resident #2, she was able to state she was receiving the medication when she asked for it . During an interview with the DON on 6/24/25 at 8:55 AM, she stated the 23 missing/undocumented muscle relaxers came from the Pharmacy Consultant when she identified the inconsistency between Resident #2's medical record . She stated she looked at all the documentation that was given to the state surveyor. She stated the medication was refilled on 3/03/25, 4/15/25, 4/30/25, and 6/05/25 per the DONs documentation. During an interview with the ADM on 6/24/25 at 8:56 AM, she stated according to Resident #2's MAR the medications were administered 8 times in March 2025, 6 times in April 2025, 3 times in May 2025 and 2 times in June 2025. She stated she was unaware the total unaccounted for was 71 undocumented/missing 500 MG Methocarbamol. Attempted to interview with LVN J on 6/19/25 at 12:40 PM. She did not answer. A text message was sent requesting a return call. Record review of The Pharmacy Consultant's statement, dated 6/25/25, revealed the following: 12/11/24: the Pharmacy Consultant stated she received a refill request for Resident #2 for Methocarbamol 500 mg and reorder sheet stated she had 6 left. The Prescription was last filled 11/21/24 for 30 tablets (ordered 3 times daily). There were 3 doses charted from 11/21 until 12/11. One dose charted on 12/14. Prescription refill was sent 12/13/24. 1/15/25 I visited once again with the DON and ADM. The DON told The Pharmacy Consultant there was no discrepancy issue, this was a charting issue that had been addressed in an inservice on 12/19/24. The ADM agreed with the DON. The DON asked the Pharmacy Consultant if she (The Pharmacy Consultant) had reviewed the chart sheets since then and The Pharmacy consultant had not. The Pharmacy Consultant stated she would go to Provider E and see what he wanted to do if there was a continued problem. Record review of a performance Improvement Plan, dated 6/5/25, revealed the plan was not specified for a particular staff but for the nursing department. The plan addressed proper documentation for PRN medication administration. The plan stated per the facility policy it was required that the nurse administering the medication will record the dose in the residents EMR. The date, time, dosage, route and results achieved should be documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676077	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonewall Living Center	931 N Broadway Aspermont, TX 79502

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy, Storage of medications, revised April 2017, revealed: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Record review of the facility's policy, Accepting Delivery of Medications, dated April 2007, revealed: Policy Statement: All staff shall follow a consistent procedure in accepting medications. Any errors noted in receiving medications shall be brought to the attention of the pharmacist and DON. Policy Interpretation and Implementation: The dispensing pharmacy, consultant pharmacist, and DON shall be notified of medication errors.