

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: 676077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Stonewall Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record reviews, the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility failed to protect and promote the rights of 13 of 16 residents (13 confidential residents) in that: The facility failed to ensure staff were not on their personal cell phones while providing Resident care. This could place residents at risk for diminished quality of life and loss of dignity and self-worth. Findings include: During an interview with confidential residents at an undisclosed date and time thirteen confidential residents stated the use of cell phones by nurses and CNAs while performing care made them feel ignored, not a priority, embarrassed, concerned the nurses and CNAs could make a mistake due to distraction by the cell phone conversation, and, most of all, their privacy was violated. During an interview thirteen confidential residents stated the use of cell phones by nurses and CNAs occurred on every shift. Confidential residents also stated staff utilize their cell phones while feeding residents during meals; residents stated the use of the cell phones while feeding residents forces those residents to have significant wait times between bites. During an interview thirteen confidential residents stated they did not know the names of the nurses and CNAs who utilized their cell phones while performing care. The confidential residents stated cell phone usage by nurses and CNAs while performing care happened in the facility so often, they said every nurse and CNA in the facility utilized their cell phone while performing care. The Residents stated most of the cellular use was via earbuds. During an interview on 02/12/26 at 1:35pm, the ADM stated residents should be provided with privacy during resident care. She stated all staff were trained on privacy, resident rights, dignity, and cell phone usage during orientation and through continuous education by department heads and the ADM. She stated staff were monitored by making rounds and correcting any issues found, and by addressing complaints. She stated cell phones should never be used in resident rooms, hallways, or nurses' stations. She stated the potential negative outcome could be mistakes and HIPAA violations. During an interview on 2/12/2026 at 2:35pm, the DON stated cell phones usage is not acceptable while performing Resident Care. The DON stated direct Resident care is a priority. The DON stated nurses and CNA are trained on resident rights, dignity, privacy, and cell phone usage during the hiring process, quarterly continuous education, and in services. The DON stated department heads are responsible for training their staff on cell phone usage in the facility. The DON stated she monitors staff for cell phone usage by performing rounds and providing continuous training. The DON stated cell phones should not be used in resident rooms, hallways, and the nurses' station. The DON the potential negative outcome of cell phone usage while performing resident care could be affecting the dignity of residents, violating their privacy and the potential for mistakes. Record review of the undated facility policy titled Resident Rights revealed the following: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence to be treated with respect, kindness, and dignity. privacy and confidentiality		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676077	Facility ID: 676077 If continuation sheet Page 1 of 3

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's 1 of 1 kitchen reviewed for food safety. The facility failed to ensure food items in the refrigerator (x1), and freezers (x5), were labeled and stored in accordance with the professional standards for food service. These failures could place residents at risk for food-borne illness and cross contamination. Findings included: During kitchen tour observations on 2/10/26 that began at 11:08 a.m. and concluded at 11:59 a.m., revealed the following: Reach-in refrigerator revealed the following: What resembled pecan pie (undated, unlabeled), chocolate cake (undated, unlabeled), and [NAME] cake (no use by date) in different clear plastic bags. Reach-in freezer #1 revealed the following: What resembled sausages (undated), hamburger patties, hot dogs, double chocolate cookies, omelets, and french fries in different clear plastic bags with no use by date. Reach-in freezer #2 revealed the following: What resembled cookies (undated, unlabeled), waffles (undated, unlabeled), and pancakes (no use by date) in different clear plastic bags. Reach-in freezer #3 revealed the following: What resembled chocolate chips (unlabeled), sweet potatoes, corn flakes, and Italian style vegetable in different clear plastic bags with no use by date. Reach-in freezer #4 revealed the following: What resembled diced onion (unlabeled), organic multicolor rice, corn flakes, and cauliflower in different clear plastic bags with no use by date. Reach-in freezer #5 revealed the following: What resembled purple onion, and beef in different clear plastic bags with no use by date. During an interview on 2/12/2026 at 1:43 p.m., regarding kitchen observations, the DM stated, it is the cook's responsibility for dating and labelling of all food items whenever the truck comes in, and I jump in to help them. The DM further stated that the food items should have been labelled and dated, I really feel that this is an isolated event, we were short staffed, the truck came in on Monday - 02/9/26, I was not here so the kitchen staff were making sure to get the truck unloaded, cook breakfast and then serve the residents. When asked about who is responsible for monitoring the dating and labelling of the food items she stated, that is my responsibility, that is what I meant by if my staff misses something, I am the one to catch it. She further stated that she has the kitchen policy and been trained to label and date food items. The DM stated, numerous things like food borne illness, and residents might not like to eat the food resulting to weight loss, when asked the potential negative outcome serving residents meals not labelled /dated. During an interview on 2/12/2026 at 2:20 p.m., with [NAME] A regarding kitchen observations, she stated everyone in the kitchen were responsible for dating and labelling all food items, that everything was supposed to be labelled and dated, and that the DM was responsible for monitoring that. When asked about the kitchen policy she stated, I have come across the policy. She further stated that not dating /labelling of the food items will potentially cause food borne illnesses because we don't know how long the food items have been there. During a phone interview on 2/12/2026 at 2:29 p.m., with the RD, regarding kitchen observations, she stated, all the kitchen staff were responsible for dating and labelling the food items. When asked if the staff have been trained on such tasks, the RD stated, yes, I believe so. She further stated that everything was supposed to be labelled /dated. When asked about who is responsible for monitoring the dating and labelling of the food items she stated, I think all the staff should, but on a daily work shift should be the DM. The RD stated that food items not labeled or dated would potentially cause food borne illness to the residents or not tasty food because it is old or spoiled, resulting in resident's weight loss. She further stated, the kitchen staff were supposed to be using the 'fifo method', first in, first out. During an interview on 2/12/2026 at 3:14 p.m., with the ADM regarding kitchen observations, she stated, all kitchen staff were responsible for ensuring food was stored and dated properly, and they were all trained on that. When asked why the food items were not labelled/dated, she stated, I can't say why they missed it. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She further stated, the DM is responsible for monitoring the dating/labelling of the food items. The ADM stated the potential negative outcomes to the residents was, using or serving expired food on those residents could be potentially harmful to the residents. Record review of the facility's policy and procedure titled, Food Storage, dated March 2021, reflected the following: Policy: Refrigerators and freezers will be kept clean and sanitized. The procedures to maintain the proper temperatures for storing cold foods will be strictly followed to prevent food borne illness. Procedure:6. Food must be stored in a properly covered container with a date and label identifying what is in the container. Foods may remain in the [NAME] box as long as content and dates are easily visible on the box. Any foods removed from the [NAME] box must be dated and labeled. 15. All of the following terms will be considered expiration dates for cold food products: Expires by date Best Used by date Use by date Sell by date.		