STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085026	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonegates	4031 Kennett Pike Greenville, DE 19807

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39058 Based on a random observation and interview it was determined that four (R13, R15, R17 and R19) residents observed during dining, food service employees utilized gloves while in the dining room to serve residents and nursing staff utilized gloves in the dining room to feed residents violating resident's dignity in their home environment. Findings include: 9/25/24 - A significant change MDS documented R17 as dependent for eating and severely cognitively impaired. 10/27/24 - An annual MDS documented R15 as dependent for eating and severely cognitively impaired. 11/10/24 - A quarterly MDS documented R19 as dependent for eating and severely cognitively impaired. 11/20/24 - A significant change MDS documented R13 as dependent for eating and severely cognitively impaired. 12/3/24 12:00 PM - An observation during dining of one E12 (Dietary Aid) was observed wearing gloves in the dining room while delivering plated food to the tables. E4 (ADON), E18 (RN) and E19 (RN) three staff members in the dining room utilized gloves while feeding R13, R15, R17 and R19. 12/3/24 Approximately 12:15 PM - During an interview with E12, E4, E18 and E19 findings were confirmed. It was reported that gloves have been in use for serving and feeding residents since the COVID pandemic. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conferences with E1 (NHA), E2 (DON), and E3 (ADON).

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39058 Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared and served in a manner that prevents food borne illness to the residents. Findings include: 12/3/24 9:30 AM - Observations in the kitchen: - The walk-in refrigerator had opened food items stored in facility containers labeled and dated as follows: tartar 10/8/24, mandarins 11/23/24, and cherries 11/18/24. There were no dates to indicate when it should be consumed, sold or discarded. In addition, bread slices and sesame buns located inside did not include any dates. The dry storage area contained a bag of tortilla chips, a bag of grits, and a pan of almonds that were not dated when they were opened or prepared. During the above observation an interview with E10 (Food Service Assistant) confirmed these findings. - The walk-in refrigerator, contained raw animal foods that were not organized and stored separately to prevent contamination of other foods. Raw fish was observed next to a container of red beans and above a container of tomato paste. In addition, raw pork was stored above a container of precooked rice and a container of mushrooms. - The ice machine scoop was observed lying on the counter next to the ice machine outside of its protective container. - The walk-in refrigerator and freezer had a case of water and a large container of ice cream on the floor. During the above observation, an interview with E11 (Dietary Aide) confirmed these findings. 12/3/24 10:00 AM - An observation of the refrigerator next to the ice machine, revealed juice containers were not dated when opened. During the above observation an interview with E12 (Dietary Aide) confirmed the juice containers were opened and had not been dated. E12 immediately removed the juice containers. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E3 (ADON).

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 51357 Based on interview, record review and review of other documentation, it was determined that for one (R17) out of one resident reviewed for hospice, the facility failed to collaborate with the hospice provider in the development of a written plan of care. Findings include: The Nursing Facility Services Agreement, dated 1/27/17, stated: 1.i Hospice and Facility will jointly develop and agree upon a coordinated, interdisciplinary plan of care . The plan of care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care . 2.d.ii Facility shall ensure that each hospice patient's care plan includes both the most recent Hospice Plan of Care and a description of the Facility Services furnished by the Facility to attain or maintain the Hospice Patient's highest practicable physical, mental and psychosocial well-being as required by federal regulations. Review of R17's clinical record revealed: 9/18/24 - R17 was admitted to hospice with a diagnosis of cerebrovascular disease. R17's facility hospice care plan, initiated on 9/17/24, included the following interventions: -Comfort measures as indicated (back rubs, turning and repositioning); -O2 (oxygen) if indicated .; -d/c (discontinue) weights; -DNR (do not resuscitate); -Monitor for s/sx (signs/symptoms) of pain; -Provide emotional support as indicated; and -Provide spiritual support as indicated. 11/13/24 - Review of R17 ' s current Hospice Provider ' s care plan documented the following interventions: -Hospice nurse to assess effectiveness of cardiopulmonary symptom relief measures including oxygen treatment and comfort modalities; -Hospice nurse to instruct regarding cardiopulmonary symptom relief measures; (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Hospice nurse to instruct regarding the safe use of oxygen and monitor its effectiveness; -Hospice nurse to coordinate plan of care with facility staff; -Hospice nurse to provide instructions/reinforcement related to urinary continence; -Hospice nurse for assessment of patient safety, instruct safety measures as applicable; -Hospice nurse to obtain O2 sats via pulse oximeter prn; -Hospice nurse to assess medication response and instruct on schedule, actions, purpose, side effects, compliance and need to report side effects to hospice staff; -Hospice nurse to assess for signs/symptoms of anxiety/terminal agitation and provide instruction regarding origin and management; -Chaplain to evaluate patient/family/caregiver and develop a plan of care; -Medical social worker to evaluate social, emotional and financial factors related to the patient's illness. Need for additional care/resources, adjustment to care and develop a plan of care; -Home Health Aide service for assistance with personal are, hygiene and activities of daily living. The facility failed to ensure that the current Hospice Provider ' s care plan approaches were included in R17 ' s facility ' s care plan. There was no order in R17's electronic medical record to monitor for pain at scheduled intervals. A review of R17's electronic medical record between 9/18/24 and 12/6/24 revealed only one instance (11/13/24) of Facility staff contacting Hospice regarding R17's change in condition where they presented with labored breathing and crackles (an abnormal lung sound). A review of R17's electronic medical record, dated 11/14/24, revealed that the lab contacted the Facility regarding critical lab values (BNP 1318) (BNP or B-type natriuretic peptide test is a blood test that indicates how well or how poorly the heart is working. Higher BNP levels can indicate heart failure and a normal BNP level for someone over age 75 is 450 pg/ML). R17's chart reveals a call placed by the Facility nurse to the primary care physician who provided new orders. There was no evidence in R17's electronic medical record that the Hospice Provider was made aware of this lab result. 11/26/24 - The Hospice IDG (Interdisciplinary Group) Comprehensive Assessment and Plan of Care Update Report documented that the Hospice RN visited R17 on 9/18/24, 11/13/24, 11/14/24 and 11/20/24. The facility lacked evidence of communication between the Hospice RN and the facility staff in R17's electronic medical record. There was no evidence that the Hospice nurse provided any of the education outlined in the hospice care plan to facility staff. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/4/24 at approximately 1:30 PM - An observation of resident's hospice binder located in the nurse's station revealed the absence of a sign in sheet for hospice staff (Hospice RN, Home Health Aide, or Medical Social Worker) between 9/18/24 through 12/6/24 and the absence of the latest Hospice IDG Comprehensive Assessment and Plan of Care Update Reports. 12/4/24 at approximately 2:00 PM - During an interview, E3 (ADON) revealed that the hospice nurse usually comes on Thursdays, but they don't check in with us and sometimes if there is a replacement, we don't know they have been here and we have to call them to ask if the hospice nurse is coming. The nurse aide comes weekly, but their schedule changes and we can't wait for them to do care, so they just assist facility staff as they can. 12/4/24 at approximately 2:15 PM - During an interview, E10 (LPN) stated, we talk to the hospice nurse about the resident's status when she comes, but we don't chart that. 12/5/24 - In response to the Surveyor's request with the facility management, the Hospice Provider furnished the Hospice IDG Comprehensive Assessment and Plan of Care Update Reports from 11/12/24 and 11/26/24. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39058 Based on observation and interview it was determined that for two random observations of the laundry room, the facility failed to handle, store and process linens to prevent the spread of infection. 12/4/24 9:30 AM - The following was observed in the laundry area: - The door from the washer room to the dryer (clean) room was open. -The room with the washing machines had blue rags on the floor to the right of the washer and a cell phone was plugged in and laying on top of a washer. -The soiled room contained an office desk, resident emergency water supply, a cell phone on the desk and a cart with clean linen that had a cover on it. 12/4/24 9:35 AM - In an interview E16 (Laundress) confirmed the door was open. 12/4/24 9:45 AM - In an interview with E14 (Supply Supervisor), the open doors were discussed and it was confirmed that the door between the soiled and clean are to be closed at all times. 12/05/24 8:32 AM - The following was observed in the laundry area: - The door from the washer room to the dryer (clean) room was propped open with a large linen cart. - The soiled room contained an office desk, small bag of soiled laundry, resident emergency water source and clean linen that had a cover on it. 12/5/24 8:35 AM - In an interview E17 (Laundress), confirmed the location of the soiled linen room and the contents. The stack of residents emergency water source and a cart of covered clean linen that is not used anymore. 12/6/24 12:15 PM - During an interview and observation with with E14 of the open laundry room doors, emergency water source for residents and the cart containing the clean linen it was confirmed that the doors between clean and soiled can not be open and the water and clean linen can not be stored in the soiled linen room. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conferences with E1 (NHA), E2 (DON), and E3 (ADON).

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 39058 Based on interview and review of other facility documentation it was determined that the facility failed to ensure that two (E13 and E14) out of five sampled employees received training on dementia management. Findings include: Review of facility training records for dementia training revealed two staff members without evidence of dementia training: - E13 was hired on 8/19/15. The facility lacked evidence of dementia training for E13. - E14 was hired on 3/28/18. The facility lacked evidence of dementia training for E14. 12/5/24 PM - An interview with E15 (HR Director) confirmed that the above two employees did not have the required dementia training. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conferences with E1 (NHA), E2 (DON) and E3 (ADON).