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	12/12/2025

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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, it was determined that for two (R18 and R27) out of three residents reviewed for accidents, the facility failed to accurately reflect R18 and R27's status by documenting their medication, carbidopa-levodopa, as an anticonvulsant. Findings include: 1. Review of R18's clinical record revealed: 11/3/23 - R18 was admitted to the facility with diagnosis including but was not limited to, Parkinson's disease.11/3/23 - E9 (MD) ordered in R18's EMR, carbidopa-levodopa oral tablet 25-100 mg - give 1.5 tablet by mouth three times a day for Parkinsons.9/20/25 - R18's annual MDS (Minimum Data Set) documented that R18 was taking an anti-convulsant.12/1/25 - R18's significant change MDS documented that R18 was taking an anti-convulsant.12/9/25 1:30 PM - A review of R18's medication orders lacked evidence that R18 was ordered any anti-convulsant medications at these times. The facility inaccurately documented carbidopa-levodopa as an anti-convulsant on R18's two MDS assessments.2. Review of R27's clinical record revealed:5/26/24 - R27 was admitted to the facility, with diagnoses including but was not limited to, Parkinson's disease.11/25/25 - E11 (MD) ordered in R27's EMR, carbidopa-levodopa oral tablet 25-100 mg - give 3 tablets by mouth four times a day for Parkinsons.10/18/25 - R27's quarterly MDS documented that R27 was taking an anti-convulsant. 12/9/25 1:35 PM - A review of R27's medication orders lacked evidence that R27 was ordered any anti-convulsant medications.The facility inaccurately documented carbidopa- levodopa as an anti-convulsant on R27's quarterly MDS assessment.12/10/25 11:59 AM - During an interview, E10 (RNAC) stated, That is how I have been coding Sinemet (carbidopa-levodopa) for years. since they [CMS] started tracking anti-convulsant medication. That is how I was taught that Sinemet is coded as an anti-convulsant.12/10/25 12:05 PM - The finding was reviewed with E10 (RNAC).

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, it was determined that for one (R29) out of five residents reviewed for unnecessary medications, the facility failed to include the required members in the care planning conference. Findings include:Review of R29's record revealed:12/9/25 - A facility form titled CARE CONFERENCE SIGN IN SHEET listed review dates of 5/27/25, 8/21/25 and 11/13/25 with participant signatures including an RN, LPN, RDN (Registered Dietitian Nutritionist) and an RNAC (Registered Nurse Assessment Coordinator).12/11/2025 8:50 AM - During an interview, E4 (LPN) confirmed that residents' medical providers do not attend or participate in care plan meetings. 12/12/2025 8:38 AM - During an interview, when asked who attends the care plan / IDT (Interdisciplinary Team) meetings, E2 (DON) reported the DON, RNAC, dietary and family attend. When asked if residents' medical providers participate in the care plan meetings, by either attending or providing input, E2 confirmed they do not. E2 then reviewed the 11/13/25 2:43 PM progress note titled Plan of Care Note, and E2 confirmed that there was no documentation of participation or input from R 29's medical provider.12/12/25 12:30 PM - Finding reviewed with E1(NHA), E2 and E3 (ADON) during exit conference.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview and record review, it was determined that for one (R18) out of three residents reviewed for accidents, the facility failed to have evidence of attempted alternatives, bed rail assessment, review of the risks and benefits and obtain informed consent prior to installation and use of bilateral bed rails. Findings include: Review of R18's clinical record revealed:9/20/25 - The annual MDS assessment documented R18's BIMS as 11 (moderate cognitive impairment); active diagnoses included Parkinson's disease and dementia; and R18 required substantial/maximum staff assistance with rolling left and right in bed and lying to sitting on the side of the bed.12/10/25 1:48 PM - Observation revealed R18 in bed for a nap with the bilateral quarter side rails positioned up.12/10/25 3:38 PM - Observation revealed R18 in bed with the bilateral quarter side rails positioned up.Review of R18's clinical record lacked evidence of alternatives attempted, bed rail assessment, informed consent with review of risks and benefits and a bed rail care plan for the use of bilateral bed rails.12/11/25 9:15 AM - During an interview, E5 (CNA) stated that the resident requires assistance to turn left and right in bed and requires a hoyer lift for transfers. E5 stated that R18 does not use the bed rails. 12/11/25 9:30 AM - During an interview, E4 (LPN) stated that the resident has Parkinson's disease and her hands would shake. E4 stated that the resident needs to have her hands guided by staff to use the bed rails and directed to hold on. E4 stated that the resident will hold on.12/11/25 11:35 AM - During a combined interview with E1 (NHA) and E2 (DON), surveyors reviewed the requirements needed prior to installation and use of the bilateral bed rails for R18. No bed rail information prior to 12/11/25 was provided to the surveyor.The facility lacked evidence of the requirements needed prior to installation and use of R18's bilateral quarter bed rails.12/12/25 12:30 PM - Finding was reviewed during the exit conference with E1, E2 and E3 (ADON).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that for one (R18) out of three residents reviewed for accidents, the facility failed to ensure each residents' records were accurate and complete. Findings include: Review of R18's clinical record revealed: 11/3/23 - R18 was admitted to the facility with diagnoses including but not limited to, Parkinson's disease and anxiety disorder.11/18/25 - E11 (MD) ordered in R18's EMR, Lorazepam (Ativan) oral tablet 0.5 mg- give 1 tablet by mouth every 6 hours as needed for anxiety or nausea and/or vomiting or agitation.This order was discontinued on 11/24/25. 11/24/25 - E11 ordered in R18's EMR, Lorazepam oral tablet 0.5 mg- give 1 tablet by mouth every 6 hours as needed for anxiety or nausea and/or vomiting or agitation for 14 days.This order was discontinued on 12/8/25. 12/8/25 3:52 PM - E11 documented in R18's EMR physician note, Resident is on PRN Ativan, we have seen positive benefit and will continue 1 month. 12/8/25 - E11 ordered in R18's EMR, Lorazepam oral tablet 0.5 mg- give 1 tablet by mouth every 6 hours as needed for anxiety or nausea and/or vomiting or agitation for 30 days. 12/9/25 9:09 AM - A review of R18's November 2025 and December 2025 MAR (Medications Administration Record) and the facility narcotic sheet for R18's lorazepam revealed that no doses of PRN lorazepam have been given to R18 during those months. 12/11/25 10:44 AM - During an interview, E3 (ADON) confirmed that no doses of lorazepam had been given to R18 during November and December 2025. E3 stated, .She [R18] is not taking the med (medication) so it is likely that we will discontinue it.The facility failed to have evidence of R18 receiving any doses of lorazepam that collaborated the 12/8/25 physician note stating that positive benefit had been noted in R18 as a result of the drug.12/14/25 12:30 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation and interview, it was determined that for one (R18) out of three residents reviewed for accidents, the facility failed to ensure that R18's bed rail was included in a routine, preventative maintenance program. Findings include:12/10/25 - Observations at 1:48 PM and 3:38 PM revealed R18 in bed with bilateral quarter bed rails positioned up.12/11/25 11:35 AM - During a combined interview with E1 (NHA) and E2 (DON), surveyors reviewed the bed rail inspection requirement as part of the maintenance program.The facility lacked evidence that R18's bed rail was included in a routine, preventative maintenance program prior to 12/10/25.12/12/25 12:30 PM - Finding was reviewed during the exit conference with E1, E2 and E3 (ADON).

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on record review and interview, it was determined that for two (E7 and E8) out of ten employees reviewed for training, the facility lacked evidence of QAPI training. Findings include: 3/26/25 - E8 (housekeeping) started working at the facility.8/7/25 - E7 (dietary) started working at the facility.12/11/25 1:24 PM - A review of the staff training revealed E7 (dietary) and E8 (housekeeping) lacked evidence of QAPI (Quality Assurance and Performance Improvement) training.12/11/25 1:24 PM - During an interview, E12 (Scheduling Coordinator) confirmed that there was no evidence of E7 and E8 completing QAPI training. 12/12/25 12:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).