

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Stonegate Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 Stonegate Blvd Fort Worth, TX 76109	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46403 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments for two (Medication Cart #1 and Medication Cart #2) of four medication carts and nurses' station counter (Hall 200- East Station) reviewed for medication storage. 1. The facility failed to lock Medication Cart #1 and Medication Cart #2 on 01/02/25, leaving all medications on the cart accessible on Hall 100 (West Station). 2. The facility failed to secure medications on the nurses' station counter on Hall 200 (East Station) on 01/03/25 at 5:30 AM. These failures could place residents at risk for drug diversions. Findings included: Observation on 01/02/25 at 3:30 PM revealed Medication Cart #1 was unlocked, and the top and second drawers were open completely facing a resident room. Observation of Medication Cart #2 revealed the medication cart was unlocked, and the drawers were facing the open entry way. Observation on 01/03/25 at 5:30 AM of the 200 Hall (East Station) revealed medications were left out unattended, in reach of residents, and visible at the nurses' station counter: *Theophylline ER 300 mg tab, quantity: 30 *Potassium CL Micro ER 10 meq tab, quantity: 30 *Aripiprazole 2 mg tab, quantity: 30 *Jardiance 10 mg tab, quantity: 14 *Escitalopram 10 mg tab, quantity: 30 *Atorvastatin 10 mg tab, quantity: 30 (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Stonegate Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 Stonegate Blvd Fort Worth, TX 76109	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Ezetimibe 10 mg tab, quantity: 30 *Levetiracetam 500 mg tab, quantity: 60 *Ranolazine ER 500 mg tab, quantity: 60 *Tamsulosin 0.4 mg cap, quantity: 60 *Eliquis 5 mg tab, quantity: 28 *Furosemide 20 mg tab, quantity: 30 *Isosorbide Dinitrate 20 mg tab, quantity: 90 *Metformin 1000 mg tab, quantity: 120 *Metoprolol Tartrate 75 mg tab, quantity: 60 Interview on 01/02/25 at 3:02 PM with MA H revealed medication carts were supposed to be locked when not in use. Interview on 01/03/25 at 5:35 AM with LVN G revealed the medications came in last night, and she was in the process of sorting out the medications and was putting the medications in the medication cart. Interview on 01/03/25 at 5:40 AM with LVN I, a PRN nurse, revealed medications were supposed to be put up in the medication cart or medication room when delivered. LVN I stated the medications were sorted out by name and put in the medication cart. LVN I stated residents could take the medications when left out or medication cart unlocked. Interview on 01/03/25 at 6:16 AM with LVN J revealed medication carts not being used were supposed to be locked at all times when not in use. LVN J stated residents could take medications that were left out. Interview on 01/03/25 at 6:35 AM with LVN K revealed medications could not be left out because residents could take the medications. LVN K stated medication carts could not be left unlocked when they were not being used. Interview on 01/03/25 at 11:50 AM with ADON A and ADON L revealed medications were supposed to be put up as soon as they came in. Medication carts were supposed to be locked when not being used. Interview on 01/03/25 at 1:10 PM with the DON revealed when medications were delivered the nurse should sign for the medications and put the medications away in the medication carts. DON C stated residents could take medications. Record review of the pharmacy delivery manifest dated 01/02/25 reflected the medications were delivered at 10:26 PM on 01/02/25. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Stonegate Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 Stonegate Blvd Fort Worth, TX 76109	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Security of Medication Cart, revised April 2007 reflected: The nurse must secure the medication cart during the medication pass to prevent unauthorized entry .3. The cart must be locked before nurse enters the resident's room .4. Medication carts must be securely locked at all times when out of the nurse's view.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Stonegate Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 Stonegate Blvd Fort Worth, TX 76109	
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 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. 46403 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 for 1 of 1 kitchen, in that: The facility failed to ensure food temperatures were checked on 01/03/25 while on the steam table before serving residents between 7:00 AM to 8:30 AM. These failures could place residents, who receive food from the kitchen, at risk for food contamination and foodborne illness. Findings included: Observation on 01/03/25 in the kitchen revealed the following: 7:00 AM - a pan of oatmeal, scrambled eggs, pureed, mechanical soft meat were on the steam table uncovered; 7:23 AM - [NAME] A put omelets on the steam table; 7:25 AM - toast was taken out of the oven and place in a different pan and then put on the steam table; 7:40 AM - bacon was put on top of the steam table. [NAME] A plated food without checking the temperatures; 7:56 AM - trays for 100 Hall were completed and sent out; 7:57 AM - [NAME] A added bread to the steam table; 8:16 AM - trays for 200 Hall were completed and sent out; and 8:30 AM - trays for 300 Hall were completed and sent out. Interview on 01/03/25 at 8:35 AM with [NAME] A revealed she was running behind and did not check temperatures for the breakfast food before serving. [NAME] A stated by not checking the temperatures the residents could get food that were too cold or too hot. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Stonegate Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 Stonegate Blvd Fort Worth, TX 76109	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/03/25 at 8:45 AM with the Dietary Manager revealed the [NAME] was supposed to check temperatures on the steam table before food was served to the residents. She stated food could be contaminated, and the residents could be served cold food. She stated the temperatures were checked on the days that were blank on the temperature log for December and January. The Dietary Manager stated [NAME] A wrote the temperature logs and a different place. She stated the temperatures should be written down in the log book as the temperatures are checked. She stated she checked the temperature book, and she updated the temperature log to reflect those temperatures. Interview attempted to with the facility's Dietitian on 01/03/25 at 9:00 AM via telephone; however, the Dietitian did not call back prior to exit. Interview attempted with [NAME] N on 01/03/25 at 9:00 AM via telephone; however, [NAME] N did not call back prior to exit. Interview on 01/03/25 at 1:30 PM with the Administrator revealed dietary staff should be bringing trays out like 10 at a time to make sure the resident's food was hot, not setting up all the trays, and then serving the residents. Record review of the facility's Food Preparation and Service policy reflected: Cooking and holding temperatures and times: The danger zone for food temperatures is between 41 degrees and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt, and cottage cheese. The following internal cooking temperatures/times for specific foods must be reached to kill or sufficiently inactivate pathogenic microorganisms: 5.Poultry and stuffed foods - 165 F. Ground meat, ground fish and eggs held for service - at least 115 F Fish and other meats - 145 F for 15 seconds .Food Distribution and service .3. The temperature of foods held in steam tables will be monitored by food service staff .		