

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 10/25/2024
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 2 of 6 residents (Residents #34 and #3) reviewed for abuse. 1. The facility failed to ensure Resident #34 had the right to be free from abuse when she was verbally and mentally abused by the Weekend Activities Assistant on 07/14/24. 2. The facility failed to ensure Resident #3 had the right to be free from abuse when he was verbally and mentally abused by CNA U on 07/08/24. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 07/08/24 and ended on 07/14/24. The facility had corrected the noncompliance before the investigation began. These failures placed residents at risk of abuse, trauma, and psychosocial harm. Findings included: 1. Record review of Resident #34's Admission Record, dated 10/22/24, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #34's Quarterly MDS Assessment, dated 09/13/24, reflected she had a BIMS score of 15, indicating no cognitive impairment. Her diagnoses included anxiety disorder (characterized by intense, excessive, and persistent worry and fear about everyday situations), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and psychotic disorder (a group of serious mental illnesses that all have signs of psychosis, which is characterized by an impaired relationship with reality, often including confusion, hallucinations, and delusions). Record review of Resident #34's care plan, revised on 08/22/24, reflected the following: Focus: [Resident #34] is at risk for adverse psychosocial effects related to verbal allegation .Goal: Will have no indications of psychosocial well being problems by/through review date .Interventions: Consult with: Pastoral care, Social services, Psych services .When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #34's Psychiatric Follow Up, dated 07/17/24, reflected: Staff reports: more tearful/withdrawn since an incident with staff member .Presents: in activity room with peers agreed to leave for interview .Subjective: 'not so good' said another resident came in her room and they kissed one night next day he changed details of the event to others, [the Weekend Activities Assistant] confronted her publicly about it. It made her uncomfortable, now feels others do not like her. Wants to isolate in her room to avoid perceived shame/judgement. [arrow up] dep/stress/anx denies- SI/HI, irritability, mania psychosis, insomnia, [arrow down] appetite no other concerns reported [sic]. Record review of Resident #34's Psychological Services Progress Note, dated 07/24/24, reflected: Patient's Response to Intervention: Pt is stressed and angry today - has had some conflicts with peers and is still upset and reactive to those - she is responsive to some de escalation and redirection to coping vs over focus on recent past incidents. Followed up with staff Record review of witness statement written by the Housekeeping Supervisor for Resident #34 dated 07/14/24 reflected: Today July 14, 2024, witnessed by the [WCN] and [MA D] & Nurse, The Weekend Activities Assistant said to resident 'You told [Resident #45] to come in the room, when he is not allowed in the room, and yall are going to be seperated to different facilitys.' Resident states she was yelling at her 'for kissing [Resident #45] and asking him to come in her room, and should have told him to leave the room.', Resident called her [family member] and told her about situation. Resident states she did not hit her but did not appreciate how she yelled at her, also that The Weekend Activities Assistant came to her room after word went to The Weekend Activities Assistant about situation and states- 'The Weekend Activities Assistant told me she was going to get fired because of her lying about it and you don't even feel bad about it.' Resident states- '[Resident #22] lied to [the Weekend Activities Assistant] and thats why she was trying to tell her to not allow him in her room but yelled at her. -Resident was Asked- Do you feel like you were abused?- -Residents Answer- 'No, just yelling and did not understand why [the Weekend Activities Assistant] came in here to tell her she is going to get her fired.' witness 1) X [signed by the WCN] 2) X __[blank]_____ X Resident [signed by Resident #34] X [signed by the Housekeeping Supervisor] [sic]. Observation and interview on 10/23/24 at 9:47 AM revealed Resident #34 lying in her bed in her room. Resident #34 said she was doing okay now but was very upset about what happened between her and the Weekend Activities Assistant. Resident #34 said the Weekend Activities Assistant had yelled at her because she thought something that was not true. Resident #34 said the Weekend Activities Assistant only wanted to believe the male resident, so she got mad at her and hurt her feelings by yelling at her. Resident #34 said it also embarrassed her because the Weekend Activities Assistant yelled at her in front of people and put her hand on her thigh. Resident #34 said she told someone about what happened and got the Weekend Activities Assistant fired for yelling at her. Resident #34 said it made her feel really bad about herself because it was in front of people who then took the Weekend Activities Assistant's side of things. Resident #34 said the situation made her cry and not want to leave her room. Resident #34 said lots of residents loved the Weekend Activities Assistant, including herself, until she yelled at her and things changed. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Telephone interview on 10/24/24 at 8:28 AM with Resident #34's family member revealed the family member was called one day and was told the Weekend Activities Assistant was very rude to Resident #34 and touched her leg. Resident #34's family member said then the Weekend Activities Assistant came to Resident #34's room and told her it was all her fault, they let me go. Resident #34's family member said Resident #34 was very upset and crying over the situation. Resident #34's family member said the Weekend Activities Assistant was rude on many occasions to the residents at the facility. Telephone interview on 10/23/24 at 9:20 AM with the Weekend Activities Assistant revealed Resident #34 accused her of hitting and kicking her three times. The Weekend Activities Assistant said she never laid a hand on Resident #34. The Weekend Activities Assistant said she was terminated from the facility because she went to Resident #34's room and told the resident she should not have said those things. The Weekend Activities Assistant said she never retaliated against Resident #34. The Weekend Activities Assistant said when she talked to Resident #34 at the nurse's station, there were 3 nurses standing nearby and 5 other residents. The Weekend Activities Assistant said she never got loud while talking with Resident #34 but her voice was loud to begin with. The Weekend Activities Assistant said she told Resident #34 that the resident needed to decide who she wanted to be with and what she wanted to be. The Weekend Activities Assistant said she had this conversation with Resident #34 at the nurse's station with others nearby and they could hear the conversation. The Weekend Activities Assistant said she did not think the conversation would have been embarrassing to Resident #34. The Weekend Activities Assistant said she was originally suspended based on the allegation Resident #34 made. The Weekend Activities Assistant said she did not think talking to Resident #34 was abusive or went against her rights in any way. The Weekend Activities Assistant said she had called and still talked to residents at the facility but never discussed the situation regarding her being terminated. Record review of a witness statement written by the Housekeeping Supervisor dated 07/14/24 reflected: To whom it may concern, I [Housekeeping Supervisor], I was on the west hall when I overheard Resident #34 call her [family member] to tell her the activities person [the Weekend Activities Assistant] was cussing and yelling and kicking her legs. I informed the [WCN and the Administrator] of the situation after witnessing [CNA V] tell [the Weekend Activities Assistant] that [Resident #34] is claiming abuse by her and I saw [the Weekend Activities Assistant] storm off- from investigation- it was told to me by [Resident #34] & [the Weekend Activities Assistant] 'that [the Weekend Activities Assistant] went into room to confront resident about situation because you know I did not abuse you, you will get me fired'- the [WCN] and I [the Housekeeping Supervisor] conducted investigation and sent [the Weekend Activities Assistant] home for the day per request of Admin, until investigation is completed. [sic]. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/23/24 at 10:16 AM with the Housekeeping Supervisor revealed she did not witness anything that happened between Resident #34 and the Weekend Activities Assistant on 07/14/24. The Housekeeping Supervisor said she was cleaning and coming down the hallway when Resident #34 was on the phone at the nurse's station with her family member and said that the Weekend Activities Assistant had yelled at her, was being very rude to her, and came into her room and touched her leg. The Housekeeping Supervisor said Resident #34 told her family member that she was being neglected and abused. The Housekeeping Supervisor said she went to tell the WCN who had given Resident #34 the telephone to begin with. The Housekeeping Supervisor said she called the Previous Administrator to tell her about the allegation that Resident #34 made. The Housekeeping Supervisor said she was told to go and talk to Resident #34 to get her story which was that the Weekend Activities Assistant had yelled at her at the nurse's station and in her room. The Housekeeping Supervisor said she went to talk to the Weekend Activities Assistant who said she had gone back to Resident #34's room to confront her. The Housekeeping Supervisor said she was told to send the Weekend Activities Assistant home that day on 07/14/24. The Housekeeping Supervisor said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. Interview on 10/23/24 at 10:43 AM with the Social Worker revealed Resident #34 and another resident in the facility were in a relationship until the male resident ended it. The Social Worker said Resident #34 was severely affected by it emotionally until the male resident tried to start up the relationship again. She said Resident #34 was not sure what to do and asked others to help her make the decision. She said the intention the Weekend Activities Assistant had in talking with Resident #34 about the situation was that either she wanted to be with the male resident or she did not, but the Weekend Activities Assistant did not want Resident #34 presenting one way to them and then another way to the male resident regarding their relationship. The Social Worker said on the day of the incident (07/14/24), the male resident went to Resident #34's room and there was some confusion as to whether Resident #34 invited him to see her or he went in on his own. She stated Resident #34 was already in an emotional state and misconstrued what the Weekend Activities Assistant said which was probably a training issue. The Social Worker said the problem with what the Weekend Activities Assistant did was when she went back to confront Resident #34 when she said to her look what you did, you got me fired. She stated this was not true, the Weekend Activities Assistant was only suspended pending the investigation at the time. The Social Worker said the real issue was that the Weekend Activities Assistant had talked to Resident #34 about the situation in front of everyone which made the resident feel embarrassed. The Social Worker said the Weekend Activities Assistant continued to be inappropriate when she was campaigning for herself to the other residents because the lines were blurred between employee and residents. The Social Worker said while the Weekend Activities Assistant was suspended pending the investigation, she had called residents on their personal cell phones which was viewed as retaliatory. The Social Worker said she spoke with Resident #34 who blamed herself for getting the Weekend Activities Assistant fired, so she explained to the resident that the Weekend Activities Assistant was terminated based upon her own actions. The Social Worker stated she followed-up with Resident #34 to ensure she was okay. She said she knew to report any abuse or allegation immediately to the Administrator and would do so now and that yelling at a resident was considered abuse. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a witness statement written by MA D, dated 07/14/24, reflected: I [MA D], on the above date, 07/14/24, and approximate time of 0900 [9:00 AM], I did witness [the Weekend Activities Assistant], Activity Director approach down the hallway towards [Resident #34], she had mentioned to me [Resident #22] had left a grievance on her desk regarding [Resident #45] and [Resident #34]. She continued down the hallway to [Resident #34] at the nursing station, she was a little loud and showing concern towards [Resident #34]. I did witness what seemed to be [the Weekend Activities Assistant] a bit angry at the situation. I did not witness additional conversation as I was busy. End of report. [sic]. Interview on 10/23/24 at 2:05 PM with MA D revealed the Weekend Activities Assistant had verbally abused Resident #34 very loudly in the hallway where everyone could hear it and she wrote a witness statement about it. MA D said the Weekend Activities Assistant was very angry with Resident #34 because there was a grievance written about her. MA D said she saw the Weekend Activities Assistant in the hallway upset and in passing said she was so mad about the grievance. MA D said the Weekend Activities Assistant was upset because it was like a soap opera in the facility and said the Weekend Activities Assistant said she was sick of [Resident #34] crying for days about her male friend in the facility. MA D said the Weekend Activities Assistant was saying she was sick of [Resident #34] going back and forth with her male friend because he upset Resident #34 so much. MA D said she was down the hallway passing medications when she saw Resident #34 at the nurse's station in front of everyone and the charge nurse intervened to take Resident #34 to her room away from the Weekend Activities Assistant who had just yelled at her. MA D said Resident #34 was bawling, crying, and extremely visibly upset at what had just happened. MA D said Resident #34 was very emotional about the situation for a long time because the other residents were giving her a hard time because they loved the Weekend Activities Assistant. MA D said Resident #34 for a while and would not come out of her room after the situation had occurred. MA D said now Resident #34 has reintegrated again and people have stopped talking about what happened, but Resident #34 was blamed for the Weekend Activities Assistant being terminated by other residents. MA D said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. Record review of a witness statement written by the WCN and dated 07/14/24 reflected: In the morning at the nursing station west while [Resident #34] is at the nursing station awaiting for nurse to give pain pill, [Resident #45] passed by her and where talking and I saw [the Weekend Activities Assistant] start separating them because they kissed on Thursday and she was telling them not to be in the room together, and resident was refusing, I did not let him in my room, [the Weekend Activities Assistant] replies yes he said that you called him to come. [The Weekend Activities Assistant] voice tone was really loud, and ended having resident cry- stating that she should not yell at her in the presence of many people. No touching or hitting observed. After patient talking to [family member] state she's been abused by [the Weekend Activities Assistant], who yelled at her in public and Administrator was notified. [sic]. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/24/24 at 8:15 AM with the WCN revealed she was standing at the nurse's station when the Weekend Activities Assistant came towards Resident #34. The WCN said apparently there was something that happened and she did not have the background information nor remembered the words that were said during the conversation between Resident #34 and the Weekend Activities Assistant. The WCN said the main thing she took away from it was that the Weekend Activities Assistant was yelling at Resident #34. The WCN said Resident #34 did not take it well trying and tried to tell the Weekend Activities Assistant that she did not do whatever she was accusing her of. The WCN said Resident #34 told the Weekend Activities Assistant you don't have to yell at me like that. The WCN said someone called the Previous Administrator and the Weekend Activities Assistant was to be sent home. The WCN said after the Weekend Activities Assistant was told to go home, the Weekend Activities Assistant went to Resident #34's room and said you got me fired. The WCN said Resident #34 told the Weekend Activities Assistant No, I didn't want to fire you. The WCN said the Weekend Activities Assistant should not have yelled at Resident #34, nor should she have had that conversation in public which made Resident #34 feel humiliated in front of people. The WCN said the situation happened at the nurse's station where other residents and staff were around. The WCN said when the Weekend Activities Assistant yelled at Resident #34, it was abuse even if that was how she talked that was not an excuse to treat a resident that way. The WCN said Resident #34 was crying a lot after the situation happened. The WCN said Resident #34 was at the nurse's station looking for her pain pill when she called her family member and told them that the Weekend Activities Assistant had humiliated and abused her. The WCN said staff should change the way they talk to a resident to remain respectful. The WCN said the Weekend Activities Assistant had yelled at Resident #34 twice at the nurse's station and then also went to her room on the way out of the building. The WCN said she did not consider the situation to be abuse at the time she witnessed it because she was new at the facility and other staff who witnessed it had said that was how the Weekend Activities Assistant normally talked but after the second time it happened that day, Resident #34 had called her family member to report it to them. The WCN said she did not like what was said to Resident #34 so she reported it to the Previous Administrator. The WCN said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. Record review of an undated witness statement written by CNA V reflected: In the morning on [blank space] [Resident #34] was @ the Desk crying I asked her what was going on she told me [the Weekend Activities Assistant] yelled @ her. And it wasn't right and who to talk to. I told the Nurse on duty that she wanted to report [the Weekend Activities Assistant] for yelling @ her. [sic]. Interview on 10/24/24 at 8:37 AM with CNA V revealed Resident #34 came up to her and said the Weekend Activities Assistant had yelled at her. CNA V said she told the nurse and Resident #34 was going to write a grievance about it. CNA V said Resident #34 was very upset and was crying about the situation. CNA V said she was not sure what happened or why the Weekend Activities Assistant had yelled at Resident #34. CNA V said Resident #34 had made an allegation of abuse. CNA V said she was not sure who the nurse was that told Resident #34 to file a grievance about the Weekend Activities Assistant yelling at her. CNA V said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/24/24 at 9:00 AM with Resident #34's Psychiatric NP revealed he had cared for Resident #34 before and after the incident of abuse from 07/14/24. He stated Resident #34 was very sensitive and staff had to be aware of how they said things to her and where they said them. He stated the situation made Resident #34 feel very uncomfortable at the facility. He stated the situation with the Weekend Activities Assistant easily upset Resident #34 and made her self-isolate for a few weeks but that was just his guess on the timeline. The Psychiatric NP said Resident #34 was a very anxious resident who marinated/ruminated on things easily. He stated Resident #34 self-isolated because she felt as if others did not like her due to the Weekend Activities Assistant being fired. The Psychiatric NP said Resident #34 seemed back to normal now and was out of her room enjoying activities with others. During a confidential interview with a resident, the resident revealed she talked to the Weekend Activities Assistant often on the phone. The resident stated she was not supposed to say anything but was willing to tell the surveyor what they talked about sometimes. The resident said the Weekend Activities Assistant had yelled at her before, but she never reported it to anyone. The resident said she was cleaning up the activity room one day when the Weekend Activities Assistant walked up to her face and said, Why did you do that? Now I'm not going to be able to find anything in here! The resident said she wheeled out of the room away from the Weekend Activities Assistant. The resident said she and everyone else knew that the Weekend Activities Assistant had a temper, but that did not mean she could talk to people any kind of way. The resident said it made her feel bad that the Weekend Activities Assistant yelled at her, but she figured it was related to something with the Weekend Activities Assistant's home life because she knew things were not good. The resident said she knew the Weekend Activities Assistant had yelled at a few people, but no one ever reported her. She stated she was not sure why the Weekend Activities Assistant was always yelling. The resident said she was not afraid of the Weekend Activities Assistant but did not like that she yelled at people. The resident said she overheard the Weekend Activities Assistant yelling at Resident #34 because the Weekend Activities Assistant believed the male resident over Resident #34. The resident said the Weekend Activities Assistant got upset with Resident #34 and went to talk to her at the nurses' station. The resident said she was not sure why the Weekend Activities Assistant yelled at Resident #34 in front of everyone, but it made Resident #34 very upset, made her cry, and made her not want to leave her room for a while. The resident said the Weekend Activities Assistant should not have embarrassed Resident #34 that way by yelling at her in front of everyone or yelling at her in general but the Weekend Activities Assistant let her temper get the best of her. The resident said after the Weekend Activities Assistant had to leave the facility, she said it was because she broke a rule but the Resident was not allowed to tell anyone that was what the Weekend Activities Assistant had told her. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Telephone interview on 10/24/24 at 3:00 PM with the Former Administrator revealed staff called her and told her Resident #34 made an allegation to them about the Weekend Activities Assistant, saying she cussed and yelled at her at the nurse's station. The Former Administrator told them what steps to take, including letting the Weekend Activities Assistant know she had to leave the building. The Former Administrator said the Weekend Activities Assistant did talk loud, so someone could perceive things as yelling or screaming. She stated as the Weekend Activities Assistant was leaving the facility she was retaliatory towards Resident #34. She stated the Weekend Activities Assistant put her hands on her hips and told Resident #34, Why did you say all those lies about me? You got me fired., as she was leaving the building. The Former Administrator said Resident #34 had psychological issues that could be perpetuated by the Weekend Activities Assistant's behavior towards her. She stated she had to ask the Weekend Activities Assistant not to call the residents anymore because it was putting fuel on the fire regarding her behavior because she made the residents worried about her after she got fired. She stated the Weekend Activities Assistant could not separate the residents as customers of hers and honor them with respect instead of treating them like they were her family members. The Former Administrator said a resident had reported to her that the Weekend Activities Assistant had talked loud and hateful to some people especially if they gossiped, and the residents talked about her like she was another resident and not like an employee. She stated a resident had reported that the Weekend Activities Assistant did get mad and raised her voice but she still loved the residents. She said she had to tell the resident that she still had a duty to fulfill as the Administrator to keep the residents safe. Record review of a witness statement from the Weekend Activities Assistant, dated 07/14/24 reflected: Upon arrival, I saw the grievance on the floor from [Resident #22], stating that [Resident #45] keeps coming into thier private living area uninvited, after being told to stay away- I went to [Resident #45], asked him why he can't follow our wishes to stay away from [Resident #34]. He again said 'ok, I wont go in there anymore, but tell her to quit telling me to come in.' After that, I went to [Resident #34] and asked her what happened- her story was that she doesn't want anything to do with him and he is the one that keeps pursuing her- I asked her if she knew how much this affected her Roommate- And that [Resident #22] was told by [Resident #34] that [Resident #45] had kissed her, but her story changed 3X, [Resident #34], says that I hit her leg- This is simply a bald-face lie- I did not put my hand on her, in anyway shape or form This statement is true- [signed by the Weekend Activities Assistant] [sic]. Record review of an undated and unsigned witness statement that was included in the facility's provider investigation report evidence reflected: .Even tho, [the Weekend Activities Assistant] has a temper. She was upset with us before, but we know, she loves us .If [the Weekend Activities Assistant] needs to control that more have her talk with someone .[sic]. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Provider Investigation Report, dated 07/22/24, reflected an incident date of 07/14/24 involving Resident #34 and the Weekend Activities Assistant. For the Description of the Allegation section was: Resident alleged the activity director hit her leg and yelled at her at the nurses station for kissing another resident who is no longer her friend. The Provider Response section reflected: Activity director was sent home on suspension as a precaution on Sunday following the communication. She then alleged it was abuse on Monday and no longer inappropriate comments. Resident did say that [the Weekend Activities Assistant] never hit her. She tapped her on the leg bending down to speak to her while she was sitting in her wc at the ns. Interviews with staff and other residents was completed to determine any other witnesses possible or other information related to the investigation. Education continues for MANE. Additional training added regarding separation of employees and residents and a healthy, professional boundary. Psych services were called. MD called. Medical director informed. Planned call with [Resident #34's family member] on 7/23/2024 to review final findings of the investigation [sic]. The Investigation Summary reflected: [The Weekend Activities Assistant's] communication was witnessed at the station to be loud and with her usual deep, loud voice. The problem is that the employee was informed later about the resident's comments by another CNA. She became upset and went back to resident in her room with hands on hip saying, 'Why did you lie about me.' 'You got me fired. You don't even care.' The activity director then started calling around to other residents on their personal cell phones to discuss her being upset she got fired perpetuating the theatrics of the matter further placing [Resident #34] at risk for feeling the act director has retaliated against her for reporting the matter. The resident says she frequently pits one resident against another with comments or actions. She had been counseled on multiple occasions about toning down her voice, and remaining focused on her personal feelings or beliefs with regard to residents and their needs. We feel she struggles to separate her being the residents 'friends' and being their paid employee and understanding her responses are required to be above reproach. We found through interviews, she is still calling the residents as of this evening of this report. She told another resident via text that '[Resident #34] ruined her life.' .It is unclear why she intentionally went down to the residents' room to 'confront her'. Regardless, it was inappropriate and with disregard for or lack of true understanding of the consequences of her actions. [sic]. The Provider Action Taken Post-Investigation section reflected: We recommend termination of employee for violating our policy for abuse, neglect, and retaliation/fear of reprisal for any resident. We will Continue training and add the communications and inappropriate texts and messaging to the training. Separation is required for employees. We treat our residents like family but there is a professional line. Ongoing monitoring for resident continues to ensure there are no lasting adverse outcomes related to this incident. Counseling as necessary for support services for resident. SW and Administrator will continue checking ins. [sic]. The facility investigation findings confirmed abuse had occurred. Record review of the grievances binder and log for the last three months revealed there was no grievance on file regarding the Weekend Activities Assistant yelling at Resident #34. Record review of an undated and untitled paper provided by the facility reflected personnel information for the Weekend Activities Assistant including a position start date of 11/18/20, a termination date of 07/30/24 with a termination reason of Gross Misconduct; a last work date of 07/14/24 and comments of Discourtesy to residents .please refer to separation notice. Record review of an in-service, dated 07/14/24, reflected staff were trained on the facility's policy regarding abuse and neglect, including when, what, and to whom abuse should be reported to; the WCN and CNA V had both signed the in-service. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Record review of Resident #3's Admission Record, dated 10/22/24, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #3's Annual MDS Assessment, dated 10/04/24, reflected he had a BIMS score of 13, indicating no cognitive impairment. Further review revealed he had a diagnosis of cerebral palsy (a group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth). Observation and interview on 10/23/24 at 9:30 AM of Resident #3 revealed he was in his wheelchair in the dining room alone. Resident #3 was able to remember when the CNA yelled at him. Resident #3 said the CNA was very mean to him and he felt it was abusive. Resident #3 said it made him feel bad when it happened. Resident #3 said the CNA got fired and now staff treat him very well. Record review of the facility's Provider Investigation Report dated 07/15/24 reflected the facility reported an incident involved Resident #3 on 07/08/24. The description of the allegation reflected: .The maintenance director		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and neglect of residents for 2 of 6 residents (Residents #34 and #3) reviewed for abuse. 1. The facility failed to protect Resident #34 from retaliation after the Weekend Activities Assistant was suspended based on an allegation of abuse on 07/14/24. 2. The facility failed to protect Resident #3 from verbal and mental abuse by CNA U on 07/08/24. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 07/08/24 and ended on 07/14/24. The facility had corrected the noncompliance before the investigation began. These failures placed residents at risk of ongoing abuse, trauma, and psychosocial harm. Findings included: 1. Record review of the facility's policy, revised December 2016, and titled Abuse Investigation and Reporting reflected: .5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. [sic]. Record review of Resident #34's Admission Record, dated 10/22/24, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #34's Quarterly MDS Assessment, dated 09/13/24, reflected she had a BIMS score of 15, indicating no cognitive impairment. Her diagnoses included anxiety disorder (characterized by intense, excessive, and persistent worry and fear about everyday situations), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and psychotic disorder (a group of serious mental illnesses that all have signs of psychosis, which is characterized by an impaired relationship with reality, often including confusion, hallucinations, and delusions). Record review of Resident #34's care plan, revised on 08/22/24, reflected the following: Focus: [Resident #34] is at risk for adverse psychosocial effects related to verbal allegation .Goal: Will have no indications of psychosocial well being problems by/through review date .Interventions: Consult with: Pastoral care, Social services, Psych services .When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. Record review of Resident #34's Psychiatric Follow Up, dated 07/17/24, reflected: Staff reports: more tearful/withdrawn since an incident with staff member .Presents: in activity room with peers agreed to leave for interview .Subjective: 'not so good' said another resident came in her room and they kissed one night next day he changed details of the event to others, [the Weekend Activities Assistant] confronted her publicly about it. It made her uncomfortable, now feels others do not like her. Wants to isolate in her room to avoid perceived shame/judgement. [arrow up] dep/stress/anx denies- SI/HI, irritability, mania psychosis, insomnia, [arrow down] appetite no other concerns reported [sic]. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #34's Psychological Services Progress Note, dated 07/24/24, reflected: Patient's Response to Intervention: Pt is stressed and angry today - has had some conflicts with peers and is still upset and reactive to those - she is responsive to some de escalation and redirection to coping vs over focus on recent past incidents. Followed up with staff Record review of witness statement written by the Housekeeping Supervisor for Resident #34 dated 07/14/24 reflected: Today July 14, 2024, witnessed by the [WCN] and [MA D] & Nurse, The Weekend Activities Assistant said to resident 'You told [Resident #45] to come in the room, when he is not allowed in the room, and yall are going to be seperated to different facilitys.' Resident states she was yelling at her 'for kissing [Resident #45] and asking him to come in her room, and should have told him to leave the room.', Resident called her [family member] and told her about situation. Resident states she did not hit her but did not appreciate how she yelled at her, also that The Weekend Activities Assistant came to her room after word went to The Weekend Activities Assistant about situation and states- 'The Weekend Activities Assistant told me she was going to get fired because of her lying about it and you don't even feel bad about it.' Resident states- '[Resident #22] lied to [the Weekend Activities Assistant] and thats why she was trying to tell her to not allow him in her room but yelled at her. -Resident was Asked- Do you feel like you were abused?- -Residents Answer- 'No, just yelling and did not understand why [the Weekend Activities Assistant] came in here to tell her she is going to get her fired.' witness 1) X [signed by the WCN] 2) X __[blank]_____ X Resident [signed by Resident #34] X [signed by the Housekeeping Supervisor] [sic]. Observation and interview on 10/23/24 at 9:47 AM revealed Resident #34 lying in her bed in her room. Resident #34 said she was doing okay now but was very upset about what happened between her and the Weekend Activities Assistant. Resident #34 said the Weekend Activities Assistant had yelled at her because she thought something that was not true. Resident #34 said the Weekend Activities Assistant only wanted to believe the male resident, so she got mad at her and hurt her feelings by yelling at her. Resident #34 said it also embarrassed her because the Weekend Activities Assistant yelled at her in front of people and put her hand on her thigh. Resident #34 said she told someone about what happened and got the Weekend Activities Assistant fired for yelling at her. Resident #34 said it made her feel really bad about herself because it was in front of people who then took the Weekend Activities Assistant's side of things. Resident #34 said the situation made her cry and not want to leave her room. Resident #34 said lots of residents loved the Weekend Activities Assistant, including herself, until she yelled at her and things changed. Telephone nterview on 10/24/24 at 8:28 AM with Resident #34's family member revealed she was called one day and was told that the Weekend Activities Assistant was very rude to Resident #34 and touched her leg. Resident #34's family member said then the Weekend Activities Assistant came to Resident #34's room and told her it was all her fault, they let me go. Resident #34's family member said Resident #34 was very upset and crying over the situation. Resident #34's family member said the Weekend Activities Assistant was rude on many occasions to the residents at the facility. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Telephone interview on 10/23/24 at 9:20 AM with the Weekend Activities Assistant revealed Resident #34 accused her of hitting and kicking her three times. She stated she never laid a hand on Resident #34. She said she was terminated from the facility because she went to Resident #34's room and told the resident she should not have said those things. The Weekend Activities Assistant said she never retaliated against Resident #34. She said when she talked to Resident #34 at the nurses' station, there were 3 nurses standing nearby and 5 other residents. The Weekend Activities Assistant said she never got loud while talking with Resident #34, but her voice was loud to begin with. She said she told Resident #34 that the resident needed to decide who she wanted to be with and what she wanted to be. She said she had this conversation with Resident #34 at the nurse's station with others nearby and they could hear the conversation. The Weekend Activities Assistant said she did not think the conversation would have been embarrassing to Resident #34. She said she was originally suspended based on the allegation Resident #34 made. She said she did not think talking to Resident #34 was abusive or went against her rights in any way. The Weekend Activities Assistant said she had called and still talked to residents at the facility but never discussed the situation regarding her being terminated. Record review of a witness statement written by the Housekeeping Supervisor dated 07/14/24 reflected: To whom it may concern, I [Housekeeping Supervisor], I was on the west hall when I overheard Resident #34 call her [family member] to tell her the activities person [the Weekend Activities Assistant] was cussing and yelling and kicking her legs. I informed the [WCN and the Administrator] of the situation after witnessing [CNA V] tell [the Weekend Activities Assistant] that [Resident #34] is claiming abuse by her and I saw [the Weekend Activities Assistant] storm off- from investigation- it was told to me by [Resident #34] & [the Weekend Activities Assistant] 'that [the Weekend Activities Assistant] went into room to confront resident about situation because you know I did not abuse you, you will get me fired'- the [WCN] and I [the Housekeeping Supervisor] conducted investigation and sent [the Weekend Activities Assistant] home for the day per request of Admin, until investigation is completed [sic]. Interview on 10/23/24 at 10:16 AM with the Housekeeping Supervisor revealed she did not witness anything that happened between Resident #34 and the Weekend Activities Assistant on 07/14/24. She said she was cleaning and coming down the hallway when Resident #34 was on the phone at the nurse's station with her family member and said that the Weekend Activities Assistant had yelled at her, was being very rude to her, and came into her room and touched her leg. She said Resident #34 told her family member that she was being neglected and abused. The Housekeeping Supervisor said she went to tell the WCN who had given Resident #34 the telephone to begin with. She said she called the Former Administrator to tell her about the allegation that Resident #34 made. The Housekeeping Supervisor said she was told to go and talk to Resident #34 to get her story which was that the Weekend Activities Assistant had yelled at her at the nurse's station and in her room. She said she went to talk to the Weekend Activities Assistant who said she had gone back to Resident #34's room to confront her. She said she was told to send the Weekend Activities Assistant home that day on 07/14/24. The Housekeeping Supervisor said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/23/24 at 10:43 AM with the Social Worker revealed Resident #34 and another resident in the facility were in a relationship until the male resident ended it. She said Resident #34 was severely affected by it emotionally until the male resident tried to start up the relationship again. The Social Worker said Resident #34 was not sure what to do and asked others to help her make the decision. She said the intention the Weekend Activities Assistant had in talking with Resident #34 about the situation was that either she wanted to be with the male resident or she did not, but the Weekend Activities Assistant did not want Resident #34 presenting one way to them and then another way to the male resident regarding their relationship. She said on the day of the incident (07/14/24), the male resident went to Resident #34's room and there was some confusion as to whether Resident #34 invited him to see her or he went in on his own. The Social Worker said Resident #34 was already in an emotional state and misconstrued what the Weekend Activities Assistant said which was probably a training issue. She stated the problem with what the Weekend Activities Assistant did was when she went back to confront Resident #34 and she said to her, look what you did, you got me fired. The Social Worker said this was not true, the Weekend Activities Assistant was only suspended pending the investigation at the time. She said the real issue was that the Weekend Activities Assistant had talked Resident #34 about the situation in front of everyone which made the resident feel embarrassed. She said the Weekend Activities Assistant continued to be inappropriate when she was campaigning for herself to the other residents because the lines were blurred between employee and residents. The Social Worker said while the Weekend Activities Assistant was suspended pending the investigation, she had called residents on their personal cell phones which was viewed as retaliatory. She said she spoke with Resident #34 who blamed herself for getting the Weekend Activities Assistant fired, so she explained that she was terminated based on her own actions. The Social Worker said she followed up with Resident #34 to ensure she was okay. She said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. Record review of a witness statement written by MA D, dated 07/14/24, reflected: I [MA D], on the above date, 07/14/24, and approximate time of 0900 [9:00 AM], I did witness [the Weekend Activities Assistant], Activity Director approach down the hallway towards [Resident #34], she had mentioned to me [Resident #22] had left a grievance on her desk regarding [Resident #45] and [Resident #34]. She continued down the hallway to [Resident #34] at the nursing station, she was a little loud and showing concern towards [Resident #34]. I did witness what seemed to be [the Weekend Activities Assistant] a bit angry at the situation. I did not witness additional conversation as I was busy. End of report. [sic]. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/23/24 at 2:05 PM with MA D revealed the Weekend Activities Assistant had verbally abused Resident #34 very loudly in the hallway where everyone could hear it and she wrote a witness statement about it. MA D said the Weekend Activities Assistant was very angry with Resident #34 because there was a grievance written about her. MA D said she saw the Weekend Activities Assistant in the hallway upset and in passing said she was so mad about the grievance. MA D said the Weekend Activities Assistant was upset because it was like a soap opera in the facility and said the Weekend Activities Assistant said she was sick of [Resident #34] crying for days about her male friend in the facility. MA D said the Weekend Activities Assistant was saying she was sick of [Resident #34] going back and forth with her male friend because he upset Resident #34 so much. MA D said she was down the hallway passing medications when she saw Resident #34 at the nurse's station in front of everyone and the charge nurse intervened to take Resident #34 to her room away from the Weekend Activities Assistant who had just yelled at her. MA D said Resident #34 was bawling, crying, and extremely visibly upset at what had just happened. MA D said Resident #34 was very emotional about the situation for a long time because the other residents were giving her a hard time because they loved the Weekend Activities Assistant. MA D said Resident #34 for a while and would not come out of her room after the situation had occurred. MA D said now Resident #34 has reintegrated again and people have stopped talking about what happened, but Resident #34 was blamed for the Weekend Activities Assistant being terminated by other residents. MA D said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. Record review of a witness statement written by the WCN and dated 07/14/24 reflected: In the morning at the nursing station west while [Resident #34] is at the nursing station awaiting for nurse to give pain pill, [Resident #45] passed by her and where talking and I saw [the Weekend Activities Assistant] start separating them because they kissed on Thursday and she was telling them not to be in the room together, and resident was refusing, I did not let him in my room, [the Weekend Activities Assistant] replies yes he said that you called him to come. [The Weekend Activities Assistant] voice tone was really loud, and ended having resident cry- stating that she should not yell at her in the presence of many people. No touching or hitting observed. After patient talking to [family member] state she's been abused by [the Weekend Activities Assistant], who yelled at her in public and Administrator was notified. [sic]. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/24/24 at 8:15 AM with the WCN revealed she was standing at the nurse's station when the Weekend Activities Assistant came towards Resident #34. The WCN said apparently there was something that happened and she did not have the background information nor remembered the words that were said during the conversation between Resident #34 and the Weekend Activities Assistant. The WCN said the main thing she took away from it was that the Weekend Activities Assistant was yelling at Resident #34. The WCN said Resident #34 did not take it well trying and tried to tell the Weekend Activities Assistant that she did not do whatever she was accusing her of. The WCN said Resident #34 told the Weekend Activities Assistant you don't have to yell at me like that. The WCN said someone called the Former Administrator and the Weekend Activities Assistant was to be sent home. The WCN said after the Weekend Activities Assistant was told to go home, the Weekend Activities Assistant went to Resident #34's room and said you got me fired. The WCN said Resident #34 told the Weekend Activities Assistant No, I didn't want to fire you. The WCN said the Weekend Activities Assistant should not have yelled at Resident #34, nor should she have had that conversation in public which made Resident #34 feel humiliated in front of people. The WCN said the situation happened at the nurse's station where other residents and staff were around. The WCN said when the Weekend Activities Assistant yelled at Resident #34, it was abuse even if that was how she talked that was not an excuse to treat a resident that way. The WCN said Resident #34 was crying a lot after the situation happened. The WCN said Resident #34 was at the nurse's station looking for her pain pill when she called her family member and told them that the Weekend Activities Assistant had humiliated and abused her. The WCN said staff should change the way they talk to a resident to remain respectful. The WCN said the Weekend Activities Assistant had yelled at Resident #34 twice at the nurse's station and then also went to her room on the way out of the building. The WCN said she did not consider the situation to be abuse at the time she witnessed it because she was new at the facility and other staff who witnessed it had said that was how the Weekend Activities Assistant normally talked but after the second time it happened that day, Resident #34 had called her family member to report it to them. The WCN said she did not like what was said to Resident #34 so she reported it to the Former Administrator. The WCN said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. Record review of an undated witness statement written by CNA V reflected: In the morning on [blank space] [Resident #34] was [at] the Desk crying I asked her what was going on she told me [the Weekend Activities Assistant] yelled [at] her. And it wasn't right and who to talk to. I told the Nurse on duty that she wanted to report [the Weekend Activities Assistant] for yelling [at] her [sic]. Interview on 10/24/24 at 8:37 AM with CNA V revealed Resident #34 came up to her and said the Weekend Activities Assistant had yelled at her. CNA V said she told the nurse and Resident #34 was going to write a grievance about it. CNA V said Resident #34 was very upset and was crying about the situation. CNA V said she was not sure what happened or why the Weekend Activities Assistant had yelled at Resident #34. CNA V said Resident #34 had made an allegation of abuse. CNA V said she was not sure who the nurse was that told Resident #34 to file a grievance about the Weekend Activities Assistant yelling at her. CNA V said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/24/24 at 9:00 AM with Resident #34's Psychiatric NP revealed he had cared for Resident #34 before and after the incident of abuse from 07/14/24. He stated Resident #34 was very sensitive and staff had to be aware of how they said things to her and where they said it. He stated the situation made Resident #34 feel very uncomfortable at the facility. He said the situation with the Weekend Activities Assistant easily upset Resident #34 and made her self-isolate for a few weeks but that was just his guess on the timeline. Resident #34's Psychiatric NP said Resident #34 was a very anxious resident who marinated/ruminated on things easily. He said Resident #34 self-isolated because she felt as if others did not like her due to the Weekend Activities Assistant being fired. He stated Resident #34 seemed back to normal now and was out of her room enjoying activities with others. During a confidential interview with a resident, the resident revealed she talked to the Weekend Activities Assistant often on the phone and she was not supposed to say anything but was willing to tell the surveyor what they talked about sometimes. The resident said the Weekend Activities Assistant had yelled at her before, but she never reported it to anyone. The resident said she was cleaning up the activity room one day when the Weekend Activities Assistant walked up to her face and said, Why did you do that? Now I'm not going to be able to find anything in here! The resident said she wheeled out of the room away from the Weekend Activities Assistant. The resident said she and everyone else knew that the Weekend Activities Assistant had a temper but that did not mean she could talk to people any kind of way. The resident said it made her feel bad that the Weekend Activities Assistant yelled at her but she figured it was related to something with the Weekend Activities Assistant's home life because she knew things were not good. The resident said that she knew the Weekend Activities Assistant had yelled at a few people but no one ever reported her and she was not sure why the Weekend Activities Assistant was always yelling. The resident said she was not afraid of the Weekend Activities Assistant but did not like that she yelled at people. The resident said she overheard the Weekend Activities Assistant yelling at Resident #34 because the Weekend Activities Assistant believed the male resident over Resident #34. The resident said the Weekend Activities Assistant got upset with Resident #34 and went to talk to her at the nurse's station. The resident said she was not sure why the Weekend Activities Assistant yelled at Resident #34 in front of everyone but it made Resident #34 very upset, made her cry, and made her not want to leave her room for a while. The resident said the Weekend Activities Assistant should not have embarrassed Resident #34 that way by yelling at her in front of everyone or yelling at her in general but the Weekend Activities Assistant let her temper get the best of her. The resident said after the Weekend Activities Assistant had to leave the facility, she said it was because she broke a rule but the Resident was not allowed to tell anyone that was what the Weekend Activities Assistant had told her. (continued on next page)		

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Telephone interview on 10/24/24 at 3:00 PM with the Former Administrator revealed staff called her and told her that Resident #34 made an allegation to them about the Weekend Activities Assistant, saying she cussed and yelled at her at the nurse's station. She stated she told them what steps to take, including letting the Weekend Activities Assistant know she has to leave out of the building. She said the Weekend Activities Assistant did talk loud and so someone could perceive things as yelling or screaming. The Former Administrator said on the Weekend Activities Assistant's way out of the facility she was retaliatory towards Resident #34 when she put her hands on her hips and told Resident #34 Why did you say all those lies about me? You got me fired. while she was leaving the building. She stated Resident #34 had psychological issues that could be perpetuated by the Weekend Activities Assistant's behavior towards her. The Former Administrator said she had to ask the Weekend Activities Assistant not to call the residents anymore because it was putting fuel on the fire regarding her behavior because she made the residents worried about her after she got fired. She said the Weekend Activities Assistant could not separate the residents as customers of hers and honor them with respect instead of treating them like they were her family members. The Former Administrator said a resident had reported to her that the Weekend Activities Assistant had talked loud and hateful to some people especially if they gossiped and the residents talked about her like she was another resident and not like an employee. She said a resident had reported that the Weekend Activities Assistant did get mad and raised her voice but she still loved the residents. The Former Administrator said she had to tell the resident that she still had a duty to fulfill as the Administrator to keep the residents safe. Record review of a witness statement from the Weekend Activities Assistant, dated 07/14/24 reflected: Upon arrival, I saw the grievance on the floor from [Resident #22], stating that [Resident #45] keeps coming into thier private living area uninvited, after being told to stay away- I went to [Resident #45], asked him why he can't follow our wishes to stay away from [Resident #34]. He again said 'ok, I wont go in there anymore, but tell her to quit telling me to come in.' After that, I went to [Resident #34] and asked her what happened- her story was that she doesn't want anything to do with him and he is the one that keeps pursuing her- I asked her if she knew how much this affected her Roommate- And that [Resident #22] was told by [Resident #34] that [Resident #45] had kissed her, but her story changed 3X, [Resident #34], says that I hit her leg- This is simply a bald-face lie- I did not put my hand on her, in anyway shape or form This statement is true- [signed by the Weekend Activities Assistant] [sic]. Record review of an undated and unsigned witness statement that was included in the facility's provider investigation report evidence reflected: .Even tho, [the Weekend Activities Assistant] has a temper. She was upset with us before, but we know, she loves us .If [the Weekend Activities Assistant] needs to control that more have her talk with someone [sic] (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Provider Investigation Report, dated 07/22/24, reflected an incident date of 07/14/24 involving Resident #34 and the Weekend Activities Assistant. The Description of the Allegation section reflected: Resident alleged the activity director hit her leg and yelled at her at the nurses station for kissing another resident who is no longer her friend. The Provider Response section reflected: Activity director was sent home on suspension as a precaution on Sunday following the communication. She then alleged it was abuse on Monday and no longer inappropriate comments. Resident did say that [the Weekend Activities Assistant] never hit her. She tapped her on the leg bending down to speak to her while she was sitting in her wc at the ns. Interviews with staff and other residents was completed to determine any other witnesses possible or other information related to the investigation. Education continues for MANE. Additional training added regarding separation of employees and residents and a healthy, professional boundary. Psych services were called. MD called. Medical director informed. Planned call with [Resident #34's family member] on 7/23/2024 to review final findings of the investigation [sic]. The Investigation Summary reflected: [The Weekend Activities Assistant's] communication was witnessed at the station to be loud and with her usual deep, loud voice. The problem is that the employee was informed later about the resident's comments by another Cna. She became upset and went back to resident in her room with hands on hip saying, 'Why did you lie about me.' 'You got me fired. You don't even care.' The activity director then started calling around to other residents on their personal cell phones to discuss her being upset she got fired perpetuating the theatrics of the matter further placing [Resident #34] at risk for feeling the act director has retaliated against her for reporting the matter. The resident says she frequently pits one resident against another with comments or actions. She had been counseled on multiple occasions about toning down her voice, and remaining focused on her personal feelings or beliefs with regard to residents and their needs. We feel she struggles to separate her being the residents 'friends' and being their paid employee and understanding her responses are required to be above reproach. We found through interviews, she is still calling the residents as of this evening of this report. She told another resident via text that '[Resident #34] ruined her life.' .It is unclear why she intentionally went down to the residents' room to 'confront her'. Regardless, it was inappropriate and with disregard for or lack of true understanding of the consequences of her actions. [sic]. The Provider Action Taken Post-Investigation section reflected: We recommend termination of employee for violating our policy for abuse, neglect, and retaliation/fear of reprisal for any resident. We will Continue training and add the communications and inappropriate texts and messaging to the training. Separation is required for employees. We treat our residents like family but there is a professional line. Ongoing monitoring for resident continues to ensure there are no lasting adverse outcomes related to this incident. Counseling as necessary for support services for resident. SW and Administrator will continue checking ins. [sic]. The Facility Investigation Findings confirmed abuse had occurred. Record review of the grievances binder and log for the last 3 months revealed there was no grievance on file regarding the Weekend Activities Assistant yelling at Resident #34. Record review of an undated and untitled paper provided by the facility reflected personnel information for the Weekend Activities Assistant including a position start date of 11/18/20, a termination date of 07/30/24 with a termination reason of Gross Misconduct; a last work date of 07/14/24 and comments of Discourtesy to residents .please refer to separation notice. Record review of an in-service, dated 07/14/24, reflected staff were trained on the facility's policy regarding abuse and neglect, including when, what, and to whom abuse should be reported to; the WCN and CNA V had both signed the in-service. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Record review of Resident #3's Admission Record, dated 10/22/24, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #3's Annual MDS Assessment, dated 10/04/24, reflected he had a BIMS score of 13, indicating no cognitive impairment. Further review revealed he had a diagnosis of cerebral palsy (a group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth). Observation and interview on 10/23/24 at 9:30 AM revealed Resident #3 in his wheelchair in the dining room alone. Resident #3 was able to remember when the CNA yelled at him. Resident #3 said the CNA was very mean to him, and he felt it was abusive. Resident #3 said it made him feel bad when it happened. Resident #3 said the CNA got fired and now staff treat him very well. Record review of the facility's Provider Investigation Report dated 07/15/24 reflected the facility reported an incident involved Resident #3 on 07/08/24. The description of the allegation section reflected: .The maintenance director then saw and heard the employee yell at [Resident #3] to get in his room . The Description of the assessment section reflected: [Resident #3] feels she was rude yelling at him to go to his roo[TRUNCATED]		

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported to the facility Administrator immediately but no later than 2 hours for 1 of 6 residents (Resident #34) reviewed for abuse and neglect. The facility failed to immediately notify their Abuse Coordinator (the Former Administrator) when the Weekend Activities Assistant had yelled at Resident #34 at the nurse's station in front of other residents and staff on 07/14/24. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 07/14/24 and ended on 07/14/24. The facility had corrected the noncompliance before the investigation began. This failure placed residents at risk of continued abuse, trauma, and psychosocial harm. Findings included: Record review of the facility's Reporting Abuse to Facility Management policy, revised December 2009 reflected the following: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management .3. All personnel, residents, family members, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse .9. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy. Record review of Resident #34's Admission Record, dated 10/22/24, reflected the was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #34's Quarterly MDS Assessment, dated 09/13/24, reflected she had a BIMS score of 15, indicating no cognitive impairment. Her diagnoses included anxiety disorder (characterized by intense, excessive, and persistent worry and fear about everyday situations), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and psychotic disorder (a group of serious mental illnesses that all have signs of psychosis, which is characterized by an impaired relationship with reality, often including confusion, hallucinations, and delusions). Record review of Resident #34's care plan, revised on 08/22/24, reflected the following: Focus: [Resident #34 is at risk for adverse psychosocial effects related to verbal allegation .Goal: Will have no indications of psychosocial well being problems by/through review date .Interventions: Consult with: Pastoral care, Social services, Psych services .When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. (continued on next page)		

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 10/23/24 at 9:47 AM revealed Resident #34 lying in her bed in her room. Resident #34 said she was doing okay now but was very upset about what happened between her and the Weekend Activities Assistant. Resident #34 said the Weekend Activities Assistant had yelled at her because she thought the resident said something to her friend by telling him to come to her room but she never told him to do that. Resident #34 said the Weekend Activities Assistant only wanted to believe the male resident, so she got mad at Resident #34 and hurt her feelings by yelling at her. Resident #34 said it also embarrassed her because the Weekend Activities Assistant yelled at her in front of people and put her hand on her thigh. Resident #34 said she told someone about what happened and got the Weekend Activities Assistant fired for yelling at her. Resident #34 said it made her feel really bad about herself because it was in front of people who then took the Weekend Activities Assistant's side of things. Resident #34 said the situation made her cry and not want to leave her room. Resident #34 said lots of residents loved the Weekend Activities Assistant, including herself, until she yelled at her and things changed. Telephone interview on 10/24/24 at 8:28 AM with Resident #34's family member revealed she was called one day and was told that the Weekend Activities Assistant was very rude to Resident #34 and touched her leg. Resident #34's family member said then the Weekend Activities Assistant came to Resident #34's room and told her it was all her fault, they let me go. Resident #34's family member said Resident #34 was very upset and crying over the situation. Resident #34's family member said the Weekend Activities Assistant was rude on many occasions to the residents at the facility. Record review of the facility's Provider Investigation Report, dated 07/22/24, reflected an incident date of 07/14/24 involving Resident #34 and The Weekend Activities Assistant. The Description of the Allegation section reflected: Resident alleged the activity director hit her leg and yelled at her at the nurses station for kissing another resident who is no longer her friend. The Provider Response section reflected: .Education continues for MANE . The Provider Action Taken Post-Investigation section reflected: We recommend termination of employee for violating our policy for abuse, neglect, and retaliation/fear of reprisal for any resident. We will Continue training and add the communications and inappropriate texts and messaging to the training [sic] . The facility investigation findings reflected the facility confirmed abuse had occurred. Record review of a witness statement from the Weekend Activities Assistant, dated 07/14/24 reflected: Upon arrival, I saw the grievance on the floor from [Resident #22], stating that [Resident #45] keeps coming into thier private living area uninvited, after being told to stay away- I went to [Resident #45], asked him why he can't follow our wishes to stay away from [Resident #34]. He again said 'ok, I wont go in there anymore, but tell her to quit telling me to come in.' After that, I went to [Resident #34] and asked her what happened- her story was that she doesn't want anything to do with him and he is the one that keeps pursuing her- I asked her if she knew how much this affected her Roommate- And that [Resident #22] was told by [Resident #34] that [Resident #45] had kissed her, but her story changed 3X, [Resident #34], says that I hit her leg- This is simply a bald-face lie- I did not put my hand on her, in anyway shape or form This statement is true- [signed by the Weekend Activities Assistant] [sic]. (continued on next page)		

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 10/23/24 at 9:20 AM with the Weekend Activities Assistant revealed Resident #34 accused her of hitting and kicking her three times. The Weekend Activities Assistant said she never laid a hand on Resident #34. The Weekend Activities Assistant said she was terminated from the facility because she went to Resident #34's room and told the resident she should not have said those things. The Weekend Activities Assistant said she never retaliated against Resident #34. The Weekend Activities Assistant said when she talked to Resident #34 at the nurse's station, there were 3 nurses standing nearby and 5 other residents. The Weekend Activities Assistant said she never got loud while talking with Resident #34 but her voice was loud to begin with. The Weekend Activities Assistant said she told Resident #34 that the resident needed to decide who she wanted to be with and what she wanted to be. The Weekend Activities Assistant said she had this conversation with Resident #34 at the nurse's station with others nearby and they could hear the conversation. The Weekend Activities Assistant said she did not think the conversation would have been embarrassing to Resident #34. The Weekend Activities Assistant said she was originally suspended based on the allegation Resident #34 made. The Weekend Activities Assistant said she did not think talking to Resident #34 was abusive or went against her rights in any way. The Weekend Activities Assistant said she had called and still talked to residents at the facility but never discussed the situation regarding her being terminated. Interview on 10/23/24 at 2:05 PM with MA D revealed she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. (continued on next page)		

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/24/24 at 8:15 AM with the WCN revealed she was standing at the nurse's station when the Weekend Activities Assistant came towards Resident #34. The WCN said apparently there was something that happened and she did not have the background information nor remembered the words that were said during the conversation between Resident #34 and the Weekend Activities Assistant. The WCN said the main thing she took away from it was that the Weekend Activities Assistant was yelling at Resident #34. The WCN said Resident #34 did not take it well trying and tried to tell the Weekend Activities Assistant that she did not do whatever she was accusing her of. The WCN said Resident #34 told the Weekend Activities Assistant you don't have to yell at me like that. The WCN said someone called the Former Administrator and the Weekend Activities Assistant was to be sent home. The WCN said after the told the Weekend Activities Assistant to go home, the Weekend Activities Assistant went to Resident #34's room and said, you got me fired. The WCN said Resident #34 told the Weekend Activities Assistant No, I didn't want to fire you. The WCN said the Weekend Activities Assistant should not have yelled at Resident #34, nor should she have had that conversation in public which made Resident #34 feel humiliated in front of people. The WCN said the situation happened at the nurse's station where other residents and staff were around. The WCN said when the Weekend Activities Assistant yelled at Resident #34, it was abuse even if that was how she talked that was not an excuse to treat a resident that way. The WCN said Resident #34 was crying a lot after the situation happened. The WCN said Resident #34 was at the nurse's station looking for her pain pill when she called her family member and told them that the Weekend Activities Assistant had humiliated and abused her. The WCN said staff should change the way they talk to a resident to remain respectful. The WCN said the Weekend Activities Assistant had yelled at Resident #34 twice at the nurse's station and then also went to her room on the way out of the building. The WCN said she did not consider the situation to be abuse at the time she witnessed it because she was new at the facility and other staff who witnessed it had said that was how the Weekend Activities Assistant normally talked but after the second time it happened that day, Resident #34 had called her family member to report it to them. The WCN said she did not like what was said to Resident #34 so she reported it to the Former Administrator. The WCN said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. Interview on 10/24/24 at 8:37 AM with CNA V revealed Resident #34 came up to her and said the Weekend Activities Assistant had yelled at her. CNA V said she told the nurse and Resident #34 was going to write a grievance about it. CNA V said Resident #34 was very upset and was crying about the situation. CNA V said she was not sure what happened or why the Weekend Activities Assistant had yelled at Resident #34. CNA V said Resident #34 had made an allegation of abuse but she did not report it to the Former Administrator. CNA V said she had been told to report any allegation of abuse to the Former Administrator but did not think about it at the time. CNA V said she realized that she should have immediately reported the allegation of abuse to the Former Administrator and would immediately report an allegation to the current Administrator. CNA V said she was not sure who the nurse was that told Resident #34 to file a grievance about the Weekend Activities Assistant yelling at her. CNA V said she knew to report any abuse or allegation immediately to the Administrator and would do so now, and that yelling at a resident was considered abuse. Telephone interview on 10/24/24 at 3:00 PM with the Former Administrator revealed staff called her and told her that Resident #34 made an allegation to them about the Weekend Activities Assistant, saying she cussed and yelled at her at the nurse's station. The Former Administrator told them what steps to make, including letting the Weekend Activities Assistant know she has to leave out of the building. (continued on next page)		

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/24/24 at 3:22 PM with the Administrator revealed he started at the facility on 10/03/24 and was not fully aware of the self-reports from July. The Administrator said he expected staff to treat residents with dignity and respect. The Administrator said staff were not allowed to yell at residents and that would be considered abuse. The Administrator said all staff were trained on the facility's abuse policy and were expected to follow it. The Administrator said all staff were responsible for ensuring residents were free from abuse. The Administrator said all staff knew to report abuse immediately to him, as the Abuse Coordinator. The Administrator said if a resident was abused it could destroy their emotional state, cause them to feel disrespected or belittled, or could cause them to become depressed. Record review of an in-service, dated 07/14/24, reflected staff were trained on the facility's policy regarding abuse and neglect, including when, what, and to whom abuse should be reported to; the WCN and CNA V had both signed the in-service. The Administrator was notified on 10/24/24 at 4:58 PM, that a past non-compliance IJ situation had been identified due to the above failures.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good grooming, and personal hygiene for 1 of 22 residents (Resident #74) reviewed for ADL care. The facility failed to ensure Resident #74's fingernails were cleaned and cut. This failure could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings included: Record review of Resident #74's Face Sheet, dated 10/24/24, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #74's MDS assessment, dated 10/03/24, reflected a BIMS score of 5 indicating severe cognitive impairment. The MDS also reflected diagnoses of stroke, hemiplegia of the right dominant side, and renal insufficiency. The MDS also reflected in Section GG that Resident #74 required substantial/maximal assistance with Activities of Daily Living. Record review of Resident #74's Care Plan, dated 10/22/24, reflected a Focus: Resident exhibits ADL Self Care Performance Deficit, requires assistance: cognitive deficit secondary to dementia disease progression, hemiplegia, impaired decision making, vision impairment. Goal: Will be cleaned, well-groomed, appropriately dressed and weight maintained through next review date. Interventions: Bathing: Bathing requires assist x 1 staff participation. Eating: requires assist x 1 staff participation. Toileting: requires assist x 1 staff participation. Transfer: requires assist x 1 staff participation assist. Bed mobility: Resident requires assist x 1 assist staff participation. Observation and interview on 10/22/24 at 10:19 AM revealed Resident #74 sitting in his wheelchair in the common in front of the nurses' station on East Hall. Resident #74's fingernails were observed to be long on both hands. The resident stated he would like his fingernails trimmed. Interview on 10/24/24 at 11:30 AM with CNA A revealed nail care was supposed to be performed on residents as needed as well as on their shower days. CNA A stated she asked the Resident #74 earlier that day if he wanted his nails trimmed, and he told her no. She said that the evening shift had completed it the day before. She also revealed that if nails were not kept trimmed and clean that residents could get an infection because they could scratch themselves resulting in a skin tear. CNA A also stated that if she did not have time to provide nail care, she should ask the next oncoming shift or her nurse to assist with nail care. She stated she had not been in-serviced on nail care since working here in the last two months. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/24/24 at 11:42 AM with LVN B revealed CNAs were responsible for nail care. LVN B stated the CNAs were supposed to check the resident's nails every time they were showered and/or bathed. LVN B also said that if she observed a resident's nails too long, she would cut them herself. LVN B continued and stated that she had not noticed Resident #74's nails needed to be cut. LVN B also stated she could not recall a policy on ADLs and nail care, nor could she remember the last time she was in-serviced on nail care. Interview on 10/24/24 at 11:52 AM with ADON A revealed it was everyone's responsibility to examine the residents' nails. ADON A stated CNAs were to provide nail care when they showered the residents and as needed. ADON A also said if a resident refused nail care, then it should be care planned. ADON A revealed long nails could cause trauma. ADON A further revealed CNAs performed nail care on non-diabetics and if residents were diabetic, then nurses were supposed to perform nail care. ADON A revealed he could not remember the last in-service on nail care. In addition, ADON A stated he spoke with the Therapy Director who provided a soft splint for the resident's hand. Record review of the facility's current Care of Fingernails/Toenails policy, dated April 2007, reflected the following: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection. General Guidelines: 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aide in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 5. Watch for and report any changes in the color of the skin around the nail bed, blueness of the nail, any signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc. 6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.		

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NAME OF PROVIDER OR SUPPLIER Stonegate Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 Stonegate Blvd Fort Worth, TX 76109	
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 3 residents (Resident #8) reviewed for respiratory therapy. LVN Y failed to ensure Resident #8's nasal cannula was changed and dated according to doctor's orders on 10/20/24. This failure could lead to respiratory infections, poor air quality, and not having their respiratory requirements met. Findings included: Record review of Resident #8's Admission Record, dated 10/24/24, reflected the resident was an [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #8's Quarterly MDS Assessment, dated 09/24/24, reflected she had a BIMS score of 15 indicating no cognitive impairment. Her diagnoses included Asthma, Chronic Obstructive Pulmonary Disease or Chronic Lung Disease. Resident #8's MDS did not address her use of oxygen therapy. Record review of Resident #8's Order Summary Report, dated 10/24/24, reflected the following: O2: Change and label water humidification and NC tubing weekly on _Sunday____and on____10-6____shift. One time a day every Sun with an order date of 10/16/23 and start dated of 10/22/23. Record review of Resident #8's care plan, revised 04/03/24, reflected the following: Focus: [Resident #8] has Oxygen Therapy as needed r/t Ineffective gas exchange .Goal: Will have no s/sx of poor oxygen absorption through the review date .Interventions: OXYGEN SETTINGS: O2 via nasal cannula/mask . Observation and interview on 10/23/24 at 9:10 AM with Resident #8 revealed she had her nasal cannula on her face being used and had a piece of tape with the date 10/14 [LVN Y's initials] on it. Resident #8 said she was doing good and was cared for by the staff. Observation and interview on 10/23/24 at 11:51 AM with Resident #8 revealed her nasal cannula was on her face being used and had a piece of tape with the date 10/14 [LVN Y's initials] on it. Resident #8 said she needed a new one because no one came to change it a few days ago like they were supposed to. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/23/24 at 11:50 AM with LVN X revealed she cared for Resident #8. LVN X said the night shift nurse on Sundays usually changed the nasal cannula for residents each week. LVN X said then on Mondays, ADON Z normally checks to make sure all the nasal cannulas were changed for each resident. LVN X said the purpose of the nasal cannula being changed was for sanitation and infection control reasons. LVN X said she had not noticed that Resident #8's nasal cannula was still dated 10/14/24 and was not changed this past Sunday (10/20/24). LVN X said usually the nurse who changed the nasal cannula would date and initial it to acknowledge when it was completed. LVN X saw Resident #8's nasal cannula dated 10/14 and said she would change it immediately. LVN X said she was not sure why it was not changed this past Sunday (10/20/24). Interview on 10/24/24 at 8:52 AM with ADON Z revealed he was told yesterday that Resident #8's nasal cannula was not changed. ADON Z said the night shift nurse on Sundays was responsible for changing a resident's nasal cannula. ADON Z said he usually came in on Mondays and checked to make sure all residents who used oxygen had their nasal cannula changed the day before. ADON Z said he worked on Sunday (10/20/24) and thought he had changed Resident #8's nasal cannula but thought he got distracted with something else and forgot. ADON Z said since he thought he had changed it himself, he did not need to check and ensure it was completed. ADON Z said the purpose of changing the nasal cannula every week was because of infection control. ADON Z said if a resident's nasal cannula was not changed it could become a breeding ground for something to colonize in the tubing. Attempted telephone interview on 10/25/24 at 9:21 AM with LVN Y was unsuccessful as there was not an answer. Interview on 10/25/24 at 3:09 PM with the Interim DON revealed a resident's nasal cannula was supposed to be changed weekly as ordered. Record review of the facility's Oxygen Administration policy, revised March 2004, reflected the following: .1. Verify that there is a physician's order for this procedure. Record review the physician's orders or facility protocol for oxygen administration		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 43791 Based on observation and interview, the facility failed to ensure, in accordance with State and Federal laws, the facility stored all drugs and biologicals in locked compartments for 1 of 5 carts (100 Hall Nurse cart) reviewed for storage. LVN C failed to secure the nurse medication cart for 100 Hall. This failure could place residents at risk of obtaining medications not prescribed to them. Findings included: Observation on 10/22/24 at 7:10 AM medication cart paraked at the nurse's station, identified by MA D as the nurse medication cart for the 100 Hall, was noted to be unlocked. All drawers, with the exception of the controlled substances drawer, were able to be opened. Five residents were sitting around the nurse's station in the common area. Interview on 10/22/24 at 7:13 AM with MA D revealed the day shift nurse was late arriving so she counted with LVN C. MA D stated LVN C requested MA D leave the 100 Hall nurse cart open so she could get something out before she left. MA D stated she was not aware LVN C had not locked the cart when she was done. MA D stated the risk of leaving a medication cart open was a resident getting medications not prescribed to them and having an allergic reaction, or an adverse outcome. Interview on 10/24/24 at 2:40 PM with the DON revealed all medication carts were to be locked when the staff member walked away from the cart. She stated the risks of leaving a cart unlocked included residents having access to medications that were not theirs and having unintended consequences or reactions. Interview on 10/25/24 at 9:06 AM with LVN C revealed she did not recall asking MA D to leave the cart open, did not recall why she might have asked her to do so, and did not recall if she did go back into the cart after handing over the keys. LVN C stated, I've slept since then. Record review of the facility's Storage of Medications policy, dated April 2007, reflected: .7. Compartments (including but not limited to drawers, cabinets .) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 48236 Based on observation, interview, and record review, the facility failed to ensure each resident was provided with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of 2 of 23 residents (Residents #41 and #239) observed. The facility failed to have an adequate supply of milk for all residents. This failure had the potential to affect all facility residents who consumed food from the facility kitchen. Findings included: Observation on 10/22/24 at 7:15 AM revealed the facility milk box contained only 12 individual servings of milk. Observation and interview on 10/22/24 at 11:53 AM with Resident #41 revealed that the resident does not receive requested milk with her breakfast approximately one time per month. Resident #41 stated she was told that they were out of milk. Resident #41 stated that in the past five weeks at the facility, she had not received milk twice. Observation and interview on 10/22/24 at 11:14 AM with Resident #239 revealed that the resident did not receive milk that morning for breakfast. The resident was eating her breakfast, and there was no milk on her tray. Resident stated that she wanted milk, but she had not received it. Interview on 10/22/24 at 7:15 AM with the Dietary Aide revealed that was not enough milk for the residents who wanted milk in the mornings with their breakfast. The Dietary Aide stated approximately once a month there was not enough milk to meet the needs of the residents. The Dietary Aide said that was everyone's responsibility to report to the Dietary Manager if they observed that the facility was running low on milk so that an emergency milk order could be placed. The Dietary Aide concluded by stating that if there was not enough milk for the residents who preferred milk with their meal, the residents would become angry and upset. The Dietary Aide revealed the department was last in-serviced on reporting when dietary items were low to the Dietary Manager the previous Friday. (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/22/24 at 7:21 AM with the Dietary Manager revealed there was not enough milk for the morning's breakfast. The Dietary Manager stated there was not enough milk because she was only allowed to order milk based on census, and sometimes more milk was needed than she was allowed to order. The Dietary Manager stated this has been the company's policy since she has worked at the facility as the Dietary Manager since January 2024. The Dietary Manager stated that in emergencies she could call for an emergency delivery of milk to be delivered to the facility. The Dietary Manager also said that the regular milk delivery was scheduled for the following day. The Dietary Manager stated that in an emergency, she could use powdered milk if necessary that she kept in her emergency food supply. The Dietary Manager revealed there was not enough milk in the building for the residents who wanted milk with their breakfast. The Dietary Manager revealed it was her responsibility to ensure there was enough milk in the facility to meet the needs of the residents. The Dietary Manager stated the cooks and the dietary aides were responsible for reporting to her if the milk supply ran low. The Dietary Manager stated she had a storage of seven days of food as an emergency supply, and she received a food delivery twice a week. The storage room was observed as well. The Dietary Manager concluded by stating that she in-serviced her staff every Monday and Friday. Interview on 10/23/24 at 12:18 PM with the Dietary District Manager revealed the Dietary Manager should have called in for an emergency delivery of milk prior to the breakfast meal. The Dietary District Manager stated it was the Dietary Manager's responsibility to keep milk in-house. The Dietary District Manager also said that if residents were not given milk, it would be a dignity issue as well as a nutritional risk. The Dietary District Manager stated staff were in-serviced two times per week. Record review of the facility's current Menus policy, dated December 2008, reflected: Policy Interpretation and Implementation .8. If a food group is missing from a resident's daily diet (e.g., dairy products), the resident will be provided an alternate means of meeting the resident's nutritional needs (e.g., calcium supplement or fortified non-dairy alternatives) 11. Menu planning will consider the cultural backgrounds and food habits of residents.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to ensure that the menu was followed for the lunch meal for 1 of 5 residents (Resident #9) reviewed for food and nutrition services. The facility failed to ensure residents on a pureed diet were served pureed bread and pureed angel food cake during the lunch meal on 10/23/24. This failure could place residents at risk for unwanted weight loss, hunger, and metabolic imbalances. Findings included: Record review of Resident #9's MDS, dated [DATE], reflected the resident was a [AGE] year-old female with primary diagnoses of dementia, stroke, and hemiplegia. Resident also was unable to complete a BIMS test. Further review reflected Resident #9 required a mechanically altered therapeutic diet. Record review of Resident #9's consolidated physician's orders, dated 10/25/24, reflected the resident had an active order for a regular diet, dysphagia advanced level 1 texture, regular consistency starting on 09/18/24. Record review of Resident #9 care plan, dated 08/20/24, reflected: Focus: Resident #9 requires a therapeutic regular diet, Dys Adv (Dysphagia Level texture. Goal: Will comply with diet through the next review date. Interventions: Alert MD/NP and document residents' inability to consume correct diet and obtain recommendations to down-grade as indicated. Offer a supplement of the resident choice when/if consumption of meal is less than 50%. Offer an alternative when/if resident does not like the meal. Provide diet as per MD order. Nurse to ensure proper diet is served. RD to evaluate and make recommendations as indicated. Record review of Order Listing Report dated 10/25/24 reflected the facility had five total residents on a pureed diet. Record review of the facility's menu for the lunch meal on 10/23/24 revealed roast turkey, honey roasted carrots, green beans, cornbread dressing, dinner roll, and brown sugar glazed angel food cake. Observation on 10/23/24 at 12:52 PM revealed Resident #9's tray ticket stated that the resident was supposed to have a dinner roll and pureed brown sugar glazed angel food cake on the tray. However, Resident #9 did not receive pureed bread nor pureed angel food cake. Resident #9 instead received applesauce instead of the cake for dessert. Observation on 10/23/24 at 1:07 PM revealed the test tray provided to survey team did not have pureed bread or pureed angel food cake. (continued on next page)		

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/24 at 1:10 PM with the Dietary Manager revealed the dessert and pureed bread were not served, but they were prepared. The Dietary Manager stated the [NAME] forgot to put the pureed bread and pureed angel food on the trays of the residents who received pureed trays. The Dietary Manager revealed it was the server's responsibility to put the individual items on the residents' trays and the Cook's responsibility to prepare the purees. The Dietary Manager said the residents who did not receive the same pureed food items as everyone else could get upset and would not receive the full nutritional value as the residents that received the regular texture trays. Interview on 10/23/24 at 1:31 PM with the District Dietary Manager revealed the pureed bread and pureed angel food cake were missing from the test tray delivered to survey team. The District Dietary Manager stated the dietary team simply did not place all the pureed items on the puree trays. The District Dietary Manager stated the resident would not receive all the nutritive value of the meal if they do not receive all the items on the menu. Record review of the facility's Therapeutic Diets policy, dated November 2015, reflected the following: Therapeutic diets shall be prescribed by the Attending Physician. The facility will strive for the fewest possible dietary restrictions .Routine menus are planned by the Food Services Manager and approved by a Registered Dietician for nutritional adequacy. The Food Services Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review the facility failed to provide food prepared in a form designed to meet individual needs for 1 of 5 residents (Resident #9) reviewed for food consistency. The facility failed to ensure Resident #9's pureed carrots were free of whole slices of carrots. This failure placed all residents, especially those with swallowing issues, at risk of aspirating or choking. Findings included: Record review of Resident #9's MDS, dated [DATE], reflected the resident was a [AGE] year-old female with primary diagnoses of dementia, stroke, and hemiplegia. Resident also was unable to complete a BIMS. Further review reflected Resident #9 required a mechanically altered therapeutic diet. Record review of Resident #9's consolidated physician's orders, dated 10/25/24, reflected the resident had an active order for a regular diet, dysphagia advanced level 1 texture, regular consistency starting on 09/18/24. Record review of Resident #9 care plan, dated 08/20/24, reflected: Focus: Resident #9 requires a therapeutic regular diet, Dys Adv (Dysphagia Level texture. Goal: Will comply with diet through the next review date. Interventions: Alert MD/NP and document residents' inability to consume correct diet and obtain recommendations to down-grade as indicated. Offer a supplement of the resident choice when/if consumption of meal is less than 50%. Offer an alternative when/if resident does not like the meal. Provide diet as per MD order. Nurse to ensure proper diet is served. RD to evaluate and make recommendations as indicated. Record review of Order Listing Report dated 10/25/24 reflected the facility had five total residents on a pureed diet. Record review of the facility's menu for the lunch meal on 10/23/24 revealed roast turkey, honey roasted carrots, green beans, cornbread dressing, dinner roll, and brown sugar glazed angel food cake. Observation on 10/23/24 at 12:45 PM revealed there were chunks of carrots in the puree portion of the puree test tray. Interview on 10/23/24 at 1:10 PM with the Dietary Manager revealed she observed the chunks of carrot slices in the pureed carrots. The Dietary Manager stated pureed foods should be smooth, like a pudding texture. The Dietary Manager said if everything was not completely pureed, the resident could choke or aspirate. The Dietary Manager stated it was the responsibility of the dietary aides and nurses to ensure the resident did not receive a puree with chunks in it. The Dietary Manager revealed she in-serviced last week on how to prepare pureed foods. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/24 at 1:31 PM with the Dietary District Manager revealed he observed the chunks of carrot slices in the pureed carrots. The Dietary District Manager stated pureed foods should not have chunks in it. He stated that it could be a choking hazard. The Dietary District Manager said the responsibility was the cook's and dietary aide's responsibility to ensure the trays do not go out with the purees incorrectly processed. Record review of the facility's undated corporate recipe for Carrots reflected: 1. For Pureed: Measure out desired # of servings into food processor. Blend until smooth. Follow directions on food thickener guidelines of specific product used in your facility for liquid and thickener measurements.		

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 1 of 3 residents (Resident #8) reviewed for accuracy of clinical records. The facility failed to ensure LVN Y accurately documented on Resident #8's TAR that her nasal cannula was not changed on 10/20/24 as ordered. This failure could place residents at risk of inaccurate medical records that could affect monitoring and medical services provided. Findings included: Record review of Resident #8's Admission Record, dated 10/24/24, reflected the resident was an [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #8's Quarterly MDS Assessment, dated 09/24/24, reflected she had a BIMS of 15 indicating no cognitive impairment. Her diagnosis included Asthma, Chronic Obstructive Pulmonary Disease or Chronic Lung Disease. Record review of Resident #8's Order Summary Report, dated 10/24/24, reflected the following: O2: Change and label water humidification and NC tubing weekly on _Sunday____ and on __10-6__ shift. One time a day every Sun with an order date of 10/16/23 and start dated of 10/22/23. Record review of Resident #8's October 2024 TAR reflected the following: O2: Change and label water humidification and NC tubing weekly on _Sunday____ and on __10-6__ shift. One time a day every Sun- Start Date- 10/23/2023 0000 with a check mark and LVN Y's initials for 10/20/24. Record review of Resident #8's care plan, revised 04/03/24, reflected the following: Focus: [Resident #8] has Oxygen Therapy as needed r/t Ineffective gas exchange .Goal: Will have no s/sx of poor oxygen absorption through the review date .Interventions: OXYGEN SETTINGS: O2 via nasal cannula/mask . Observation and interview on 10/23/24 at 9:10 AM revealed Resident #8 had her nasal cannula on her face being used and had a piece of tape with the date 10/14 [LVN Y's initials] on it. Resident #8 said she was doing good and was cared for by the staff. (continued on next page)		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/23/24 at 11:51 AM revealed Resident #8's nasal cannula was on her face being used and had a piece of tape with the date 10/14 [LVN Y's initials] on it. Resident #8 said she needed a new one because no one came to change it a few days ago like they were supposed to. Interview on 10/24/24 at 8:52 AM with ADON Z revealed if staff did not provide a treatment they should make a note why it was not done. ADON Z said if there was a check mark on a resident's TAR, that meant it was completed. ADON Z said if LVN Y did not change Resident #8's nasal cannula she should not have checked on the resident's TAR that it was completed. ADON Z said the purpose of accurate documentation on a resident's TAR was to inform the oncoming staff of what was accomplished and what still needed to be accomplished. ADON Z said there could be a gap in a resident's care if the information on their TAR was inaccurate. ADON Z said he only checked resident's TARs for completion, not accuracy. ADON Z said he believed that each nurse was responsible for what they documented. ADON Z said LVN Y was responsible for ensuring she documented accurately on Resident #8's TAR regarding the nasal cannula not being changed on Sunday (10/20/24). Attempted telephone interview on 10/25/24 at 9:21 AM with LVN Y was unsuccessful as there was not an answer. Interview on 10/25/24 at 3:09 PM with the Interim DON revealed staff were not supposed to document that they provided a treatment if they did not provide it. The Interim DON said staff were responsible for documenting accurately on a resident's TAR. Record review of the facility's Oxygen Administration policy, revised March 2004, reflected the following: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure.		