STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675759	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonegate Nursing and Rehabilitation	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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the interdisciplinary team determined if a resident was able to self-administer medications for 1 of 15 residents (Resident #20) reviewed for resident rights.The facility failed to ensure Resident #20, was clinically appropriate to self-administer nasal spray that were at the resident's bedside. The failure had the potential to place residents at risk for unsafe drug administration.Findings included:Record review of Resident #20's admission MDS, dated [DATE], reflected Resident #20 was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #20's BIMS score was 12 which indicated moderate cognitive impairment. Resident #20's active diagnoses included Hypertension (high blood pressure), Renal insufficiency (kidney failure), anxiety disorder (mental health conditions that cause excessive fear and worry).Record review of Resident #20's undated Care Plan did not address Resident #20's need or use of medications at her bedside. Record review on 02/10/26 of Resident #20's clinical records reflected no assessment was completed to indicate if Resident #20 was able to self-administer medication. Record review on 02/10/26 of Resident #20's order summary revealed Resident #20 did not have a physician's order for nasal spray. Record review on 02/10/26 of Resident #20's MAR reflected Resident #20 did not have an order for nasal spray. Observation and interview on 02/10/26 at 11:38 AM, revealed Resident #20 had a bottle of Nasal Spray at her bedside. Resident #20 stated she had the medication for a while, she administered it herself with no help from staff. Resident #20 stated she kept the medication at her bedside because sometimes her nose got dry, and she used it as needed to keep her breathing comfortably. Resident #20 stated staff had never questioned her use of the nasal spray or having it on her bedside table. Interview and observation on 02/11/26 at 1:49 PM with LVN G revealed there were no residents in the facility that were able to self-administer medication. LVN G stated he was not aware of Resident #20 having any medications at her bedside table. He revealed if there were any medications, then perhaps the resident's family brought the medications in. LVN G stepped inside Resident #20's room and removed the medication at bedside which included an over-the-counter nasal spray. LVN G educated Resident #20 that medication was not allowed at bedside, and that he would contact the physician for an order, she could ask the medication to be administered by staff anytime she needed it. LVN G stated residents were not allowed to have nasal spray at the bedside. He stated he would contact the doctor to get an order and provide the nasal spray for the resident as needed. LVN G stated residents having medications at their bedside placed other residents at risk of gaining access to the medication and misusing it. LVN G stated everyone was responsible for observing and removing medications from bedside. Interview on 02/12/2026 10:44 AM with ADON H revealed residents were not allowed to self-administer medications on their own while in the facility. ADON H stated she was notified that Resident #20 had over the counter medication at her bedside. ADON H stated it was all staff's responsibility to remove any medications found in the resident room. ADON H further stated, Angel Rounds were done to observe for oxygen, medication, call lights within reach and clear and free floors, this is the time medications should be removed and given to the nurse on the floor so she could notify the physician. ADON H stated residents having any type of medication at their bedside placed (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them at risk of over medicating or having a change of condition.Interview on 02/12/2026 at 3:35 PM with the DON revealed ambassadors were responsible for identifying and educating residents about having medications in their room. Staff were to remove the medication and notify the nurse, the nurse would then call doctor and get an order for it if resident wanted to continue taking the medication. DON stated residents were not allowed to administer their own medications. DON stated residents having medications in their room placed themselves at risk of getting duplicate treatment, overdosing and residents having medication without the nursing staff or physician knowing.Interview on 02/12/26 at 5:00 PM with the DON and Regional Leadership revealed they did not have a policy regarding residents self-administering medications, however provided their Storage of Medication listed below.Record review of the facility's Storage of Medication policy, revised April 2007, reflected the following: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior for 1 of 33 residents (Resident #64) reviewed for sanitary and comfortable environment.The facility failed to maintain Resident #64's wheelchair in a sanitary condition leaving food, liquid spills, dirt, and debris to collect down both sides of the wheelchair when observed on 02/10/26. This failure could place residents at risk of contamination and infections. Findings included: Record review of Resident #64's Quarterly MDS, dated [DATE], reflected Resident #64 was an [AGE] year-old male originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident #64's diagnoses included muscle weakness (lack of strength to move limbs or joints) and diabetes (a chronic condition causing high blood sugar due to insufficient insulin production). He had a BIMS score of 09 indicating cognitive was moderately impaired. Resident #64 required use of a manual wheelchair. Record review of Resident #64's Care Plan dated 01/29/26 revealed Resident #64 has an ADL self-care performance deficit, which requires assistance: cognitive deficit secondary to dementia disease progression, impaired decision making, limited mobility Goal: Resident #64 Will be cleaned, well-groomed, appropriately dressed and maintained through next review date. Interventions: -Resident#64 will be cleaned, well-groomed, appropriately dressed and weight maintained through next review date. Interventions: -Transfer: requires assist x2 staff participation assist mechanical lift. Bed Mobility: res requires assist x1 staff participation. Observation and interview on 02/10/26 at 10:40 AM with Resident #64 revealed he was in his wheelchair. Resident #64's wheelchair had food particles, liquid spills, dirt, and debris on both sides of the wheelchair. Resident #64 indicated he used a wheelchair for mobility throughout the facility. Resident #64 stated he was not aware his wheelchair looked dirty, and he could not recall his wheelchair being cleaned. Observation on 02/11/26 at 7:15 AM revealed Resident #64 was in his wheelchair. Resident #64's wheelchair had food particles, liquid spills, dirt, and debris on both sides of the wheelchair.Observation and interview on 02/11/26 at 10:48 AM with CNA A revealed today was her first day working with Resident #64. She said she had not observed Resident #64's wheelchair to have dried food, spills, and debris on the sides. CNA A stated aides on the overnight shift were responsible for cleaning resident wheelchairs. CNA A stated if she observed residents with dirty wheelchairs, she would just clean it herself. CNA A further stated she would not want to sit in a dirty chair, so she could imagine residents did not want to sit in a dirty chair as well. CNA A stated that when residents were in a dirty environment it placed them at risk of infection.Interview/observation on 02/11/26 at 11:20AM with LVN B revealed Resident #64's Wheelchairs was observed dirty on the sides with debris, dried food, and liquid spills. She stated she works with Resident #64 regularly on 6-2 shift. She said she had not observed Resident #64's wheelchair to have dried food on the sides, and if she would have reported to the ADON. LVN B stated aides on the overnight shift were responsible for cleaning resident wheelchairs. LVN B stated that when residents were in a dirty environment it placed them at risk of infection.Attempts to contact CNA C on the overnight (10:00 PM - 6:00AM) shift on 02/12/26 at 12:30PM was unsuccessful. Interview on 02/12/26 at 03:47PM with the DON revealed her expectation was for the night shift CNAs to clean the chair routinely and when dirty. The DON stated the overnight shift had a wheelchair cleaning schedule they were supposed to go by. The schedule was reviewed and there was no evidence the wheelchair was cleaned. The DON stated aides do not document when the task was completed so there was no indication resident chair was cleaned. She stated she was responsible of auditing that the chairs were being cleaned, and she could not recall the last time she audited. The DON stated not ensuring residents' wheelchairs were cleaned placed residents at risk of a buildup of debris and could lead to infection and dignity issue.Interview on 02/12/26 at 04:15PM with the Administrator revealed CNAs on the overnight shift (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were responsible for ensuring all wheelchairs were cleaned according to the schedule. The Administrator stated the facility was working on making another schedule and getting somebody who will be responsible of cleaning the wheelchairs. Record review of the facility's Equipment-General use for all residents policy, dated August 2006, reflected: Wheelchairs, walkers, crutches, canes are maintained by our facility for the general use of as all residents.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to assess each resident quarterly (every 3 months) using the MDS form specified by the state and approved by CMS for 1 of 5 residents (Resident #56) reviewed for assessments. The facility failed to ensure Residents #56's quarterly MDS assessment was completed within three months from the previous assessment. This failure could place residents at risk of not receiving necessary care or receiving inappropriate care for their conditions. Findings included: Record review of Resident #56's electronic health record reflected she had an entry MDS assessment completed on 10/02/25 and a significant change MDS completed on 10/09/25. There was a quarterly MDS assessment that was still in progress and had not been completed, dated 01/09/26. Her original admission date was 05/07/24 and most recent readmission date was 10/02/25. Interview on 02/12/26 at 10:45 AM with the Regional MDS Coordinator revealed she knew Resident #56's quarterly MDS was still in progress. The Regional MDS Coordinator said the facility had personnel changes recently and went a few months without having an MDS Coordinator full-time at the facility. The Regional MDS Coordinator said usually a quarterly MDS assessment was completed every 92 days. The Regional MDS Coordinator said Resident #56's was past the 92 days and was overdue. The Regional MDS Coordinator said the purpose of the quarterly MDS assessment was to collect data about the resident's care needs. The Regional MDS Coordinator said she was trained to submit quarterly MDS assessments timely but no one monitored to ensure they were completed timely. Interview on 02/12/26 at 3:34 PM with the DON revealed she knew the Regional MDS Coordinator had been working on getting caught up on MDS assessments. The DON said she had nothing to do with monitoring or completing MDS assessments. The DON said she expected all resident's MDS assessments to be completed timely. Record review of the facility's policy, revised September 2010, and titled Resident Assessment Instrument reflected: 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and review according to the following schedule:.c. At least quarterly.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 5 residents (Resident #21) reviewed for nutritional status. The facility failed to recognize, evaluate, and address timely interventions and prevent weight loss when Resident #21 experienced severe weight loss of 6.48% (8 pounds) from 01/12/26 to 02/12/26. This failure could place residents at risk for improper care, weight loss, malnutrition, and overall health decline. Findings included: Record review of Resident #21's significant change in status assessment, dated 01/16/26, reflected he was a [AGE] year-old male who was originally admitted to the facility on [DATE] and had recently readmitted to the facility on [DATE]. The MDS reflected no BIMS score was calculated. The MDS reflected he had short-term and long-term memory problems and was severely impaired in daily decision making. His active diagnoses included diabetes (chronic condition that occurs when body cannot properly use blood sugar leading to high blood sugar levels), seizure disorder or epilepsy (a medical condition characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain), and down syndrome (a genetic condition caused by the presence of an extra copy of chromosome 21, leading to developmental delays and distinct physical features). His MDS did not indicate he had any weight loss. Record review of Resident #21's Order Summary Report, dated 02/12/26, reflected the following: HS snack at bedtime, order date 01/12/26 Record review of Resident #21's Care Plan, revised 02/06/26, reflected the following: Focus: Mr./Mrs. is at risk for weight fluctuations d/t____ Changes [sic] in appetite, difficulty adjusting to new environment, recent hospitalization, mechanically altered diet, therapeutic diet 2/10/26 [sic] -5% wight [sic] loss1/13/26 [sic] -3% weight lossInterventions: Monitor weights as per facility protocol.RD to evaluate and treat. Record review of Resident #21's meal eaten percentage from 01/12/26 to 02/12/26 reflected he ate over 50% of each meal each day. Record review of Resident #21's Weights, dated 02/12/26, reflected the following:11/10/25 120 lbs.01/13/26 108 lbs.02/12/26 100.6 lbs. Record review of Resident #21's Nutrition Assessment, dated 01/20/26, reflected the following: Current Weight- 108# [sic], Usual Body Weight- 108# [sic], DBW Range?- 125# +/- 10% .There was also a check noted in the box titled Undesirable Weight Loss? Notes: No new weight in [electronic health record] noted, used recent body weight of 108# to estimate calorie/protein needs.Will continue to monitor nutritional status. Goal: gradual weight gain to IBW Recs: 1) Suggest starting protein supplement, 30 ml BID to promote wound healing 2) Recommend vitamin C & zinc for wound healing 3) weekly weights x4 to monitor weight trends. Record review of an undated and untitled piece of paper provided by CNA D reflected the following: 1-13-26.Re Admits [sic].[Resident #21's Room Number] 108.0 LB [sic] [Resident #21]. Record review of an undated and untitled piece of paper provided by CNA D reflected the following: 1-20-26.Weekly.[Resident #21's Room Number] 105.7 [Resident #21]. Record review of an undated and untitled piece of paper provided by CNA D reflected the following: 1-28-26.Weekly.[Resident #21's Room Number] 103.2 [Resident #21] Mon [sic]. Record review of the facility's monthly weights list, which was undated, reflected Resident #21 weighed 94.6 pounds. Record review of CNA D's folder where she kept all the resident's weights listed out showed on one side of the folder the following: [Resident #21] 99.4 LB, 100.1 LB Observation on 02/11/26 at 9:51 AM of Resident #21 revealed he was sitting in his wheelchair in the common area but was not interviewable. He was dressed and groomed and did not appear to be in any distress. Observation on 02/11/26 at 11:19 AM of Resident #21 revealed he was asleep in bed, his bed was low to the ground, and he had a fall mat at his bedside. Observation on 02/11/26 at 1:15 PM of Resident #21 revealed he was in the dining room sitting at a table being helped to eat his lunch. Later observation of his meal revealed he had eaten all of his meal. Interview on 02/12/26 at 10:01 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM with LVN G revealed Resident #21 had been eating very well lately after he was re-admitted from the hospital about a month or so ago. LVN G said he noted Resident #21 had weight loss when he first re-admitted but since then has been eating every meal and mostly 100% of each meal that he was aware of. LVN G said Resident #21 needed assistance to eat his meals so he ate mostly in the dining room being assisted to eat by someone. LVN G said Resident #21 was currently not receiving any nutritional supplements that he was aware of because he had not been triggered for weight loss. LVN G said during Resident #21's hospital stay, they changed his seizure medications and that seemed to have made the biggest difference in his appetite once he re-admitted . Observation and interview on 02/12/26 at 10:05 AM with CNA D and CNA E revealed they weighed Resident #21's wheelchair which was 87.8 pounds. CNA D and CNA E then brought Resident #21 to the scale in the wheelchair and they both weighed 188.8 lbs. CNA D and CNA E said that meant Resident #21 weighed 101 pounds. Interview on 02/12/26 at 10:07 AM with CNA D revealed she was responsible for obtaining resident's weights and writing them down on the pieces of paper she provided the surveyor. CNA D said she weighed Resident #21 this morning and got the weights 99.4 and 100.1 pounds. CNA D said she was only responsible for obtaining the weights and confirmed Resident #21 weighed 108 pounds upon readmission on [DATE], 105.7 pounds on 01/20/26, 103.2 pounds on 01/28/26, 99.4 pounds one day last week, and 99.4 pounds this morning. CNA D confirmed after Resident #21 ate breakfast and was weighed with the surveyor he weighed 101 pounds. CNA D said she provided her paperwork with resident weights to ADON F and DON. CNA D said she always made a copy of that days' weights and gave it to ADON F. CNA D said she was only responsible for obtaining weights for re-admitted residents, newly admitted residents, daily weighed residents, weekly weighed residents, and monthly weighed residents. CNA D said if she noticed a weight loss from one month to the next she would let ADON F and the DON know but since she did not have that information from week to week she would not know if a resident had lost weight or not. CNA D said she was not sure what ADON F did with the weight measurements she gave her after she was given a copy of them. Interview on 02/12/26 at 10:19 AM with ADON H revealed she was told about Resident #21's weight loss last month when he was re-admitted to the facility but he had also just come back from the hospital. ADON H said the other ADON (ADON F) was responsible for tracking and trending resident's weights. ADON H said ADON F and the DON went to the weight meetings together to discuss any resident's weight loss. ADON H said Resident #21 losing 7 pounds in one month was a lot of weight loss. ADON H said the RD sent her recommendations to the DON and she would follow-up on them. ADON H said she had no further information about Resident #21's weight loss. Interview on the phone on 02/12/26 at 11:14 AM with Resident #21's RP revealed he had just received a phone call from the facility letting him know about Resident #21's weight loss. Resident #21's RP said he was at the facility a few days ago and did not notice any weight loss on Resident #21. Resident #21's RP said he knew Resident #21 was not eating well while he was at the hospital about a month ago but they changed his seizure medications and that seemed to help his appetite to come back. Resident #21's RP said he was told Resident #21 lost about 7-8 pounds over the last month since being back at the facility. Interview on the phone on 02/12/26 at 11:59 AM with the RD revealed she just started consulting at the facility at the beginning of January. The RD said she recalled sending an email to the DON on 01/20/26 after completing Resident #21's assessment and noting his weight loss after his hospital stay and making recommendations. The RD said she noted there was not a new weight in the system for her to review since 11/10/25 so she looked at his hospital records which showed the 108 pounds upon re-admission. The RD said she was concerned about Resident #21's weight loss from November to January and now from January to February. The RD said normally the DON and nursing staff were good at communicating resident's weight loss to her so she could check on it. The RD said she was not sure why the facility never mentioned Resident #21 to her. The RD said her original recommendation on 01/20/26 was to add a protein supplement and weigh him weekly. The RD said she had not been back to the facility yet so she was not able to follow up to see if the facility (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said as far as she knew, Resident #21 needed assistance to eat and was eating 100% of all 3 of his meals. The DON said she did not want a significant weight loss like what Resident #21 has had over the last month and nutritional supplements would have made it more gradual or stabilized if they had been implemented earlier. The DON said since they did not have the weekly weight information they were not aware Resident #21 was losing so much weight so fast. The DON said the purpose of residents not losing weight was to maintain nutritional balance. The DON said if residents were losing weight they could become nutritionally compromised. The DON said she expected ADON F to be monitoring resident weights and reporting to her any concerns or trends of weight loss. Record review of the facility's Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, revised December 2008, reflected the following: 1. The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time.3. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weigh- actual weight) / (usual weigh) x 100]:1 month- 5% weight loss is significant; greater than 5% is severe.