DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Stonegates **DATE SURVEY COMPLETED:** December 12, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint survey was conducted at this facility on December 8, 2025, through December 12, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 35. The survey sample size was 13. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Ativan (lorazepam) - a benzodiazepine medication used to treat anxiety, insomnia, nausea and agitation; BIMS - Brief Interview for Mental Status/a structured cognitive assessment, 0-7: Severe impairment (never/rarely made decisions), 8-12: Moderately impaired (decisions poor; cues/supervision required), 13-15: Cognitively intact (decisions consistent/reasonable); CNA - Certified Nurse's Aide; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DON - Director of Nursing; EMR - electronic medical record; LPN - Licensed Practical Nurse;	3201.1.6.9.2.4 1. E 16 T spot was completed at the time of survey 12/12/25. See attached. E 8was completed by two-step ppd on 12/24/20025. Attachment G. 2. The ppd's were not completed as it was thought contract empolyees did not require a ppd prior to employment. All new hires will receive a T-spot or ppd as a part of pre hire screening. The Administrator discussed with HR director that all newly hired employees, contractors and volunteers must follow the preemployment screening requirements set forth by DHCQ. 3. The Human Resources Director/designee will verify TB results prior to the newly hired employees start date. Audits will be conducted monthly to ensure all new hire files have a verified Tb test and no screenings were missed. Attachment G-1 4. The audits will be presented to the QAPI committee at the scheduled meetings. This will be an ongoing audit until 100% compliance is achieved.	1/26/2026

Provider's Signature Michele Dennis,RN_____ Title Administrator Date ; 1/7/2026

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	MAR - Medication Administration record; MDS - Minimum Data Set/federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; mg - milligrams; NHA - Nursing Home Administrator; Parkinson's Disease - disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement and coordination; QAPI - Quality Assurance and Performance Improvement.	3201.1.2 1. The ten employees cited for lack of marijuana screening will have a drug test for marijuana by January 26, 2026 2. All current employees hired since 12/6/24, will have their files reviewed and verified for pre-employment drug testing result including marijuana/cannabis testing. Any employee missing the drug screening required will be tested by January 26, 2026 3. Audits of drug screening will be conducted by the Huma Resources Director on a monthly basis. The audit will include the complete drug test result and will be verified before the employee begins work. Attachment H 4. Audits for drug screening that includes screening for marijuana will be submitted to the QAPI committee. The audits will be conducted monthly for one year or until 100% compliance is achieved.	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement was not met as evidenced by:**		

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	Cross refer to the CMS-2567-L survey completed December 12, 2025: F641, F657, F700, F842, F909 and F944.		
3201.6.0	**Services to Residents**		
3201.6.9	**Communicable Diseases**		
3201.6.9.2	**Specific Requirements for Tuberculosis**		
3201.6.9.2.4 **S/S – D**	**Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron...** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for two (E8 and E16) out of ten employees reviewed for TB testing, the facility failed to have evidence of pre-employment TB testing. Findings include: 1/24/25 – E16 (maintenance) started to work at the facility. 3/26/25 – E8 (housekeeping) started to work at the facility. 12/10/25 11:30 AM – A review of the ten selected, recently hired employees revealed that R8 and R16 did not have TB results on record in their employee file. 12/10/25 12:32 PM – During an interview, E20 (HR) confirmed that E8 and E16 did not have a TB test on file and "were removed from the schedule" (until they acquired TB test results).		

Provider's Signature Michele Dennis,RN_____ Title Administrator Date ; 1/7/2026

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Title 16 Health and Safety Chapter 11 Subchapter IX Criminal Background Checks: Drug Testing-PPECC S/S = E	12/12/25 10 AM – The facility provided a copy of E16's T-spot TB test results, which were negative, dated 12/12/2. 12/12/25 12:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON). **1146 Mandatory Drug Screening** **(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screen...** **(b) All Applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** **(c) The Department shall promulgate regulations, regarding the pre-employment testing if all applicants, for use of all of the following illegal drugs:** **(1) Marijuana/cannabis** **(2) Cocaine** **(3) Opiate** **(4) Phencyclidines ("PCP")** **(5) Amphetamines** **(6) Any other illegal drug specified by the department under regulations promulgated under this section...** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for ten (E5, E7, E8, E10, E15, E16, E17, E18, E19, E21) out of ten employees reviewed for pre-employment drug testing, the facility failed to have evidence of pre-employment drug testing for marijuana. Findings include:		

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	12/18/24 – E15 (RN) underwent a pre-employment drug screening that did not include marijuana testing. 1/3/25 – E15 started to work in the facility. 1/16/25 - E5 (CNA) underwent a pre-employment drug screening that did not include marijuana testing. 1/21/25 – E5 started to work in the facility. 1/22/25 – E16 (maintenance) underwent a pre-employment drug screening that did not include marijuana testing. 1/24/25 – E16 started to work in the facility. 3/25/25 – E8 (housekeeper) underwent a pre-employment drug screening that did not include marijuana testing. 3/26/25 - E8 started to work in the facility. 3/27/25 – E19 (CNA) underwent a pre-employment drug screening that did not include marijuana testing. 4/2/25 – E19 started to work in the facility. 4/26/25 – E21 (RN) underwent a pre-employment drug screening that did not include marijuana testing. 5/13/25 – E21 started to work in the facility. 5/29/25 – E17 (CNA) underwent a pre-employment drug screening that did not include marijuana testing. 6/2/25 – E17 started to work in the facility.		

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	7/22/25 – E10 (RNAC) underwent a pre-employment drug screening that did not include marijuana testing. 7/29/25 – E10 started to work in the facility. 8/2/25 – E18 (LPN) underwent a pre-employment drug screening that did not include marijuana testing. 8/4/25 – E7 (dietary) underwent a pre-employment drug screening that did not include marijuana testing. 8/7/25 – E7 and E18 started work in the facility. 12/10/25 11:30 AM – A review of the ten selected, recently hired employees revealed that none of their pre- employment drug screenings had tested for marijuana. 12/10/25 12:32 PM – During an interview, E12 (Scheduling coordinator) and E20 (HR) both confirmed that the facility was not testing for marijuana in their pre-employment drug screening test. 12/12/25 12:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATES	4031 KENNETT PIKE , GREENVILLE, Delaware, 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an emergency preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		01/31/2026
F0000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility on December 8, 2025 through December 12, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 35. The survey sample size was 13. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Ativan (lorazepam) - a benzodiazepine medication used to treat anxiety, insomnia, nausea and agitation; BIMS - Brief Interview for Mental Status/a structured cognitive assessment, 0-7: Severe impairment (never/rarely made decisions), 8-12: Moderately impaired (decisions poor; cues/supervision required), 13-15: Cognitively intact (decisions consistent/reasonable); CNA - Certified Nurse's Aide; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DON - Director of Nursing; EMR - electronic medical record; LPN - Licensed Practical Nurse;	F0000		01/31/2026

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

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F0000	Continued from page 1 MAR - Medication Administration record; MDS - Minimum Data Set/federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; mg - milligrams; NHA - Nursing Home Administrator; Parkinson's Disease - disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement and coordination; QAPI - Quality Assurance and Performance Improvement.	F0000		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for	F0641	At the time of survey, the DON audited the MDS's of all residents who received carbidopa-levodopa. All the identified MDS's were corrected. The audit was given to the surveyor at the time of survey. All residents receiving carbidopa-levodopa have the potential to be affected. All MDS's have been audited and corrected at the time of survey. The RNAC did not have a clear understanding of what should be coded as an anticonvulsant on the MDS. The RNAC will be educated by the DON on accurate coding of medication classification on the MDS. This was completed on 12/31/25. See attachments A-1, A-2. The DON/designee will complete MDS audits to ensure accurate coding of section N medication classification. This will be completed weekly x3 months, then monthly ongoing through 2026. Audits will be reported to QAPI committee quarterly or until 100% compliance is achieved. See attachment A.	01/26/2026

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F0641 SS = D	Continued from page 2 each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for two (R18 and R27) out of three residents reviewed for accidents, the facility failed to accurately reflect R18 and R27's status by documenting their medication, carbidopa-levodopa, as an anticonvulsant. Findings include: 1. Review of R18's clinical record revealed: 11/3/23 – R18 was admitted to the facility with diagnosis including but was not limited to, Parkinson's disease. 11/3/23 – E9 (MD) ordered in R18's EMR, "carbidopa-levodopa oral tablet 25-100 mg – give 1.5 tablet by mouth three times a day for Parkinsons." 9/20/25 - R18's annual MDS (Minimum Data Set) documented that R18 was taking an anti-convulsant. 12/1/25 - R18's significant change MDS documented that R18 was taking an anti-convulsant. 12/9/25 1:30 PM - A review of R18's medication orders lacked evidence that R18 was ordered any anti-convulsant medications at these times. The facility inaccurately documented carbidopa-levodopa as an anti-convulsant on R18's two MDS assessments. 2. Review of R27's clinical record revealed: 5/26/24 – R27 was admitted to the facility, with diagnoses including but was not limited to, Parkinson's disease. 11/25/25 – E11 (MD) ordered in R27's EMR, "carbidopa-levodopa oral tablet 25-100 mg – give 3 tablets by mouth four times a day for Parkinsons." 10/18/25 - R27's quarterly MDS documented that R27 was taking an anti-convulsant. 12/9/25 1:35 PM - A review of R27's medication orders lacked evidence that R27 was ordered any anti-convulsant medications.	F0641		

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F0641 SS = D	Continued from page 3 The facility inaccurately documented carbidopa-levodopa as an anti-convulsant on R27's quarterly MDS assessment. 12/10/25 11:59 AM – During an interview, E10 (RNAC) stated, "That is how I have been coding Sinemet (carbidopa-levodopa) for years… since they [CMS] started tracking anti-convulsant medication. That is how I was taught that Sinemet is coded as an anti-convulsant." 12/10/25 12:05 PM – The finding was reviewed with E10 (RNAC).	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by:	F0657	The care plan meetings for the affected resident have already occurred previously. The DON discussed with the physician on requirement to participate in development of the care plan on 12/18/25. The residents under the care of the listed physician have the potential to be affected. The physician will be notified of their residents care plan meetings weekly by DON/designee. See attachment B-4. The physician will be educated by the DON on requirement to participate/contribute to the care plan. -Completed 12/31/25. See attachments B-1, B-2, B-3. Audits will be conducted by the DON/designee to ensure physician notification of care plan meetings and documentation, and will be completed weekly x3 months, then monthly through 2026. Audits will be reported to QAPI committee quarterly or until 100% compliance is achieved. See attachment B.	01/26/2026

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F0657 SS = D	Continued from page 4 Based on interview and record review, it was determined that for one (R29) out of five residents reviewed for unnecessary medications, the facility failed to include the required members in the care planning conference. Findings include: Review of R29's record revealed: 12/9/25 - A facility form titled "CARE CONFERENCE SIGN IN SHEET" listed review dates of 5/27/25, 8/21/25 and 11/13/25 with participant signatures including an RN, LPN, RDN (Registered Dietitian Nutritionist) and an RNAC (Registered Nurse Assessment Coordinator). 12/11/2025 8:50 AM – During an interview, E4 (LPN) confirmed that residents' medical providers do not attend or participate in care plan meetings. 12/12/2025 8:38 AM - During an interview, when asked who attends the care plan / IDT (Interdisciplinary Team) meetings, E2 (DON) reported the "DON, RNAC, dietary and family" attend. When asked if residents' medical providers participate in the care plan meetings, by either attending or providing input, E2 confirmed they do not. E2 then reviewed the 11/13/25 2:43 PM progress note titled Plan of Care Note, and E2 confirmed that there was no documentation of participation or input from R 29's medical provider. 12/12/25 12:30 PM - Finding reviewed with E1(NHA), E2 and E3 (ADON) during exit conference.	F0657		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F0700	The deficiency was corrected for the listed resident at the time of survey. On 12/11/2026 The consent was obtained from the family, therapy completed a an assessment of the resident using the side rail, maintenance completed the bed/side rail assessment. All residents with side rails on their bed have the potential to be affected. The DON/designee will identify those residents who require the use of quarter side rails, completed 12/31/25, see attachment C. The DON/designee will ensure all documentation is completed for identified residents, this will be completed by 1/31/25, see attachment C-1. All licensed staff will be in-serviced on the facility policy and process for initiating side rails by the DON. The training will be completed by 1/26/25. Those staff not scheduled will be trained when they return. See attachment C-2, C-3 The DON/designee will conduct audits to ensure appropriate use and documentation for quarter side	01/26/2026

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F0700 SS = D	Continued from page 5 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for one (R18) out of three residents reviewed for accidents, the facility failed to have evidence of attempted alternatives, bed rail assessment, review of the risks and benefits and obtain informed consent prior to installation and use of bilateral bed rails. Findings include: Review of R18's clinical record revealed: 9/20/25 – The annual MDS assessment documented R18's BIMS as 11 (moderate cognitive impairment); active diagnoses included Parkinson's disease and dementia; and R18 required substantial/maximum staff assistance with rolling left and right in bed and lying to sitting on the side of the bed. 12/10/25 1:48 PM – Observation revealed R18 in bed for a nap with the bilateral quarter side rails positioned up. 12/10/25 3:38 PM – Observation revealed R18 in bed with the bilateral quarter side rails positioned up. Review of R18's clinical record lacked evidence of alternatives attempted, bed rail assessment, informed consent with review of risks and benefits and a bed rail care plan for the use of bilateral bed rails. 12/11/25 9:15 AM – During an interview, E5 (CNA) stated that the resident requires assistance to turn left and right in bed and requires a hoyer lift for transfers. E5 stated that R18 does not use the bed rails. 12/11/25 9:30 AM – During an interview, E4 (LPN) stated that the resident has Parkinson's disease and her hands would shake. E4 stated that the resident needs to have her hands guided by staff to use the bed rails and directed to hold on. E4 stated that the resident will hold on. 12/11/25 11:35 AM – During a combined interview with E1 (NHA) and E2 (DON), surveyors reviewed the requirements	F0700	Continued from page 5 rails ordered. The audit will be completed monthly through 2026. Audits will be reported to QAPI committee quarterly or until 100% compliance is achieved. See attachment c-1.	

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F0700 SS = D	Continued from page 6 needed prior to installation and use of the bilateral bed rails for R18. No bed rail information prior to 12/11/25 was provided to the surveyor. The facility lacked evidence of the requirements needed prior to installation and use of R18's bilateral quarter bed rails. 12/12/25 12:30 PM – Finding was reviewed during the exit conference with E1, E2 and E3 (ADON).	F0700		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F0842	The physician corrected their documentation in the medical record on 12/17/25 at 15:43. See attachment D. Attachment D is the physician's progress note in medical record noting their error and correction to their prior note on 12/8/25 at 15:53, also noted on attachment D. Residents under the care of the listed physician that are receiving PRN psychotropics have the potential to be affected. The DON identified those residents and reviewed documentation. completed 12/30/25. see attachment D-1 The physician will be educated by DON for accurate documentation in the medical record. completed 12/31/25. see attachments D-3, D-4, D-5. The DON/designee will conduct audits to ensure accurate supporting documentation for medication renewal orders. The audit will be completed monthly through 2026. Audits will be reported to QAPI committee quarterly or until 100% compliance is achieved. see attachment D-2.	01/26/2026

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STONEGATES	**4031 KENNETT PIKE , GREENVILLE, Delaware, 19807**

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F0842 SS = D	Continued from page 7 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R18) out of three residents reviewed for accidents, the facility failed to ensure each residents' records were accurate and complete. Findings	F0842		

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F0842 SS = D	Continued from page 8 include: Review of R18's clinical record revealed: 11/3/23 – R18 was admitted to the facility with diagnoses including but not limited to, Parkinson's disease and anxiety disorder. 11/18/25 – E11 (MD) ordered in R18's EMR, "Lorazepam (Ativan) oral tablet 0.5 mg- give 1 tablet by mouth every 6 hours as needed for anxiety or nausea and/or vomiting or agitation." This order was discontinued on 11/24/25. 11/24/25 - E11 ordered in R18's EMR, "Lorazepam oral tablet 0.5 mg- give 1 tablet by mouth every 6 hours as needed for anxiety or nausea and/or vomiting or agitation for 14 days." This order was discontinued on 12/8/25. 12/8/25 3:52 PM – E11 documented in R18's EMR physician note, "Resident is on PRN Ativan, we have seen positive benefit and will continue 1 month." 12/8/25 - E11 ordered in R18's EMR, "Lorazepam oral tablet 0.5 mg- give 1 tablet by mouth every 6 hours as needed for anxiety or nausea and/or vomiting or agitation for 30 days." 12/9/25 9:09 AM – A review of R18's November 2025 and December 2025 MAR (Medications Administration Record) and the facility narcotic sheet for R18's lorazepam revealed that no doses of PRN lorazepam have been given to R18 during those months. 12/11/25 10:44 AM – During an interview, E3 (ADON) confirmed that no doses of lorazepam had been given to R18 during November and December 2025. E3 stated, "...She [R18] is not taking the med (medication) so it is likely that we will discontinue it." The facility failed to have evidence of R18 receiving any doses of lorazepam that collaborated the 12/8/25 physician note stating that "positive benefit" had been noted in R18 as a result of the drug. 12/14/25 12:30 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0842		
F0909 SS = D	Resident Bed CFR(s): 483.90(d)(3)	F0909	At the time of the survey, the maintenance director immediately completed the bed/side rail inspection using the Bionix testing device. The report was given	01/26/2026

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F0909 SS = D	Continued from page 9 §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that for one (R18) out of three residents reviewed for accidents, the facility failed to ensure that R18's bed rail was included in a routine, preventative maintenance program. Findings include: 12/10/25 - Observations at 1:48 PM and 3:38 PM revealed R18 in bed with bilateral quarter bed rails positioned up. 12/11/25 11:35 AM - During a combined interview with E1 (NHA) and E2 (DON), surveyors reviewed the bed rail inspection requirement as part of the maintenance program. The facility lacked evidence that R18's bed rail was included in a routine, preventative maintenance program prior to 12/10/25. 12/12/25 12:30 PM - Finding was reviewed during the exit conference with E1, E2 and E3 (ADON).	F0909	Continued from page 9 to the surveyor. All residents with quarter side rails on their beds have the potential to be affected. Audit was completed and beds with side rails were identified. See attachment C. The maintenance director/designee will complete an inspection of all beds with quarter side rails. This will be completed by 1/26/25. The beds will be added to the quarterly preventative maintenance schedule. See attached E-1 . All newly ordered side rails will be inspected at the time of application with the Bionix testing device and added to the quarterly preventive maintenance schedule. The maintenance director/designee will submit findings from the quarterly inspections to the QAPI committee. Quarterly reports for preventative maintenance related to bed rail safety are an ongoing program. See attachment E-2	
F0944 SS = D	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for two (E7 and E8) out of ten employees reviewed for training, the facility lacked evidence of QAPI training. Findings include: 3/26/25 – E8 (housekeeping) started working at the facility.	F0944	Both E7 and E8 have been trained in QAPI, see attachment F and F-1 for their quiz score. Completion date 1/7/2026 All new hires will have QAPI training as evidenced by a read and sign training. See attachment F-2 The facility did not provide education for those employees who were not exclusive to health care. The facility will now ensure all new hires receive the QAPI training and it will be kept on file in their respective department. Human Resources will add this training to the new hire information packet. Audits will be conducted monthly on all newly hired personnel to determine that they have completed the read and sign training for QAPI, see attachment F-3. The Human Resources Director will conduct the monthly audit and report findings to the QAPI committee on a quarterly basis until 100% compliance is achieved.	01/26/2026

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F0944 SS = D	Continued from page 10 8/7/25 – E7 (dietary) started working at the facility. 12/11/25 1:24 PM – A review of the staff training revealed E7 (dietary) and E8 (housekeeping) lacked evidence of QAPI (Quality Assurance and Performance Improvement) training. 12/11/25 1:24 PM – During an interview, E12 (Scheduling Coordinator) confirmed that there was no evidence of E7 and E8 completing QAPI training. 12/12/25 12:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F0944		