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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: November 23, 2021

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 from November 18, 2021 through November 23, 2021. 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 36. The survey sample totaled 23 residents.	F tag 656 1. Care plan of the resident identifier R16 has been updated as indicated as of 12/10/2021 2. The facility has determined that all residents have the potential to be affected. Care plans will continue to be reviewed on a quarterly/as needed and with a significant change. Resident's with care plans related to sleep hygiene will be reviewed and revised if indicated by 12/17/2021 3. All team members responsible for writing care plans will be re-educated on the process for developing a comprehensive care plan. 4. Care plans will be reviewed at each scheduled care plan meeting by the MDS coordinator. All care plans will be updated as indicated. The Primary nurse will be a part of the review process and assist in updating the care plan. The Director of Nursing/designee, will complete random weekly audits of care plans for 6 weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Reports will be submitted to the QAPI committee for review until such time the QAA committee deems substantial compliance has been achieved.	Completed: 12/22/21
3201.0	**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 is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed November 23, 2021: F656, F756, F757.		

Provider's Signature Kim M. Cass Title administrator Date 12/13/21

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		F tag 756 1. A review of the medication regimen was conducted by the Director of Nursing for R6 on 12/8/2021. The statement of Therapeutic Suggestion was faxed to the Attending Physician on 12/9/21 with a note regarding it lacked a proper response. 2. All residents have the potential to be affected by this deficient practice. 3. The facility procedure regarding the timely review and action on Therapeutic Suggestions will be reviewed with all staff nurses as well as the guidelines for a timely response. 4. All Therapeutic Suggestions will be addressed within 30-days of receipt of the report. The Director of Nursing/designee will review the Therapeutic Suggestions to determine that they were addressed timely and properly. The reports will be reviewed monthly for 6-months to ensure compliance. Audit results will be submitted to the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	Completed: 12/22/21

Provider's Signature Kim M. Carr Title Administrator Date 12/13/21

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F tag 757

1. The medication regimen for R16 was reviewed with the physician on 12/7/21. The indication for the medication is documented in the medical record. The supplement ordered is indicated for sleep hygiene and a monitoring system has been put in place on 12/10/21

2. The facility has determined that all residents who have orders for medications and supplements for sleep hygiene have a monitoring system in place for sleep hygiene. This was completed on 12/10/21.

3. All Licensed staff will by in-serviced regarding the facility policy for Unnecessary Drugs by 12/22/21

4. The Director of Nursing/designee will complete weekly random audits for six consecutive weeks of new mediation/supplements orders to ensure that the appropriate monitoring system is in place and documented in the medical record.

5. Audited reports will be submitted to the QAPI committee for until the committee deems substantial compliance has been achieved.

Completed:

12/22/21

Provider's Signature Kim M Carr Title Administrator Date 12/13/21

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	085026	A. BUILDING _____ B. WING _____	C 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATES	4031 KENNETT PIKE GREENVILLE, DE 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
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from November 18, 2021 through November 23, 2021. The facility census was 36 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were cited.	E 000		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training.	E 037		12/31/21

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

Electronically Signed | 12/10/2021

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.

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E 037	Continued From page 1 (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 2 (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.	E 037		

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E 037	Continued From page 3 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster	E 037		

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E 037	Continued From page 4 authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that for three (E8, E12, and E13) out of ten sampled employees, the facility failed to provide initial emergency preparedness training. Findings include: Review of facility records for emergency preparedness training revealed three staff members without evidence of training upon hire. - E8 (RN) - no record of initial emergency preparedness training.	E 037	1. An Emergency Preparedness training packet will be included in the new employee hire process. The packet will include emergency contact numbers, various emergency scenarios with staff actions and suggested responses and an Incident Command chart for chain of command in an emergency situation.E8, E12 and E13 will be given the training packet in order to assure they have received the new hire information. 2. The packet will also be distributed to all	

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E 037	Continued From page 5 - E12 (PT) - no record of initial emergency preparedness training. - E13 (PT) - no record of initial emergency preparedness training. 11/22/21 3:21 PM - In an email correspondence, E2 (DON) stated the facility does not include emergency preparedness training in new hire orientation. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 11/23/21, beginning at 3:29 PM.	E 037	existing employees and flip charts will be located in every department for reference. 3. The policy for the distribution of the initial training as well as follow up training as required, i.e. participation in fire drills and disaster drills for all new hires and existing employees has been updated. 4. The Human Resource Manager and Scheduling Coordinator are responsible for the on-boarding process for all new employees which include the completion of the new hire checklist, this checklist has been updated to include a new hire Emergency Preparedness/Disaster Training packet. The file will be completed when the checklist is completed. 5. The status of the completion of the new hire emergency training exercises held per regulation will be presented to the QAPI committee at each quarterly meeting. We expect 100% compliance with the use of the training packet for new hires by December 31,2021. 6. The signature page for the Emergency/Disaster training packet will be collected by the HR and Scheduling Coordinator and maintained in the HR office until the completion of the employee's 90 probationary period. The signature page will be maintained in a separate binder until the end of the employee's 90 day probationary period.	
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from November 18, 2021 through November 23, 2021. The deficiencies contained in this report are based on	F 000		

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F 000	Continued From page 6 observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 36. The survey sample totaled 23 residents. Abbreviations/definitions used in this report are as follows: AD - Activities Director; ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; COVID-19/Coronavirus - a respiratory illness that can be spread person to person; DON - Director of Nursing; DPS - Director of Plant Services; LPN - Licensed Practical Nurse; LTC - Long Term Care; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		12/22/21

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F 656	Continued From page 7 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a care plan for sleeplessness for one (R16) out of five residents reviewed for unnecessary medication review. Findings include: Review of R16's clinical record revealed: 6/30/21 - R16 was prescribed a supplement for	F 656	1. Care plan of the resident identifier R16 has been updated as indicated as of 12/10/2021 2. The facility has determined that all residents have the potential to be affected. Care plans will continue to be reviewed on a quarterly/as needed and with a significant change. Resident's with	

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F 656	Continued From page 8 sleeplessness. 11/21/21 - Review of R16's care plans did not reveal a care plan for R16's sleeplessness. During an interview on 11/22/21 at 10:50 AM, E2 (DON) confirmed there was no care plan to address R16's sleeplessness. These findings were reviewed during the exit conference on 11/23/21 at 3:29 PM with E1 (NHA) and E2.	F 656	care plans related to sleep hygiene will be reviewed and revised if indicated by 12/17/2021 3. All team members responsible for writing care plans will be red-educated on the process for developing a comprehensive care plan. 4. Care plans will be reviewed at each scheduled care plan meeting by the MDS coordinator. All care plans will be updated as indicated. The Primary nurse will be a part of the review process and assist in updating the care plan. The Director of Nursing/designee, will complete random weekly audits of care plans for 6 weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Reports will be submitted to the QAPI committee for review until such time the QAA committee deems substantial compliance has been achieved.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		12/22/21

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F 756	Continued From page 9 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R6) out of five residents reviewed for unnecessary medication review, the facility failed to ensure recommendations by the pharmacist were reviewed by the physician. Findings include: The facility policy on Medication Regimen Review (MRR) and Reporting, last updated November 2017, indicated, "6. Resident specific MRR	F 756	1. A review of the medication regimen was conducted by the Director of Nursing for R6 on 12/8/2021. The statement of Therapeutic Suggestion was faxed to the Attending Physician on 12/9/21 with a note regarding it lacked a proper response. 2. All residents have the potential to be affected by this deficient practice.	

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F 756	Continued From page 10 recommendations and findings are documented and acted upon by the nursing care center and /or physician." 12/11/2020- A monthly MRR for R6 documented a recommendation from the pharmacist and lacked evidence of physician review or response. The MRR section for physician response was left unchecked, blank, and without a physician signature. During an interview on 11/22/21 at 12:45 PM, E2 (DON) confirmed that the facility was unable to locate a physician response to R6's 12/11/2020 MRR. Findings were reviewed during the exit conference on 11/23/21 at 3:29 PM with E1 (NHA) and E2.	F 756	3. The facility procedure regarding the timely review and action on Therapeutic Suggestions will be reviewed with all staff nurses as well as the guidelines for a timely response. 4. All Therapeutic Suggestions will be addressed within 30-days of receipt of the report. The Director of Nursing/designee will review the Therapeutic Suggestions to determine that they were addressed timely and properly. The reports will be reviewed monthly for 6-months to ensure compliance. Audit results will be submitted to the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085026	A. BUILDING _____ B. WING _____	C 11/23/2021

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

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F 757	Continued From page 11 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R16) out of five residents reviewed for necessary medications, the facility failed provide evidence of adequate monitoring for sleeplessness. Findings include: Review of R16's clinical record revealed: 6/30/21 - R16 was prescribed a supplement for sleeplessness. 11/21/21 - Review of R16's behavior monitoring sheets lacked evidence of monitoring for sleeplessness. During an interview on 11/22/21 at 10:50 AM, E2 (DON) confirmed the facility was not monitoring R16's sleeplessness and lacked evidence of the effectiveness of R16's supplement for sleep. Findings were reviewed during the exit conference on 11/23/21 at 3:29 PM with E1 (NHA) and E2.	F 757	1. The medication regimen for R16 was reviewed with the physician on 12/7/21. The indication for the medication is documented in the medical record. The supplement ordered is indicated for sleep hygiene and a monitoring system has been put in place on 12/10/21 2. The facility has determined that all residents who have orders for medications and supplements for sleep hygiene have a monitoring system in place for sleep hygiene. This was completed on 12/10/21. 3. All Licensed staff will by in-serviced regarding the facility policy for Unnecessary Drugs by 12/22/21 4. The Director of Nursing/designee will complete weekly random audits for six consecutive weeks of new mediation/supplements orders to ensure that the appropriate monitoring system is in place. and documented in the medical record. Audited reports will b e submitted to the QAPI committee for until the committee deems substantial compliance has been	

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F 757	Continued From page 12	F 757	achieved.	