PRINTED: 02/10/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STONEGATE STONEGATE STONEGATE STONEGATE OR RALEIGH, NC 27615 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYINS INFORMATION) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients: (i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients with a severely in the staff to client ratio is 1 to 4; (ii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4. This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility failed to assure adequate staff-to-client ratios were met. The finding is: During morning observations in the home on 2/8/21 at 9.55am, the home manager (HM) was alone in the home with 6 clients. Further observations revealed all 6 clients where up and dressed. Further observations revealed the HM was alone with the 6 clients until 11:36am when the qualified intellectual disabilities professional (QIDP) came into the home. During an interview on 2/8/21, the HM stated the third shift staff had left the home "around 4:40am."	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
STONEGATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL TAGY DEFICIENCY MUST SEPTIMENT DEFICIENCY DEFICIE			34G293	B. WING			02/	09/2021
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W 187 DIRECT CARE STAFF CFR(s): 483.430(d)(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients: (i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2; (ii) For each defined residential living unit serving clients who famely a severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 6.4. This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility failed to assure adequate staff-to-client ratios were men. The finding is: During morning observations in the home on 2/8/21 at 9:55am, the home manager (HM) was alone in the home with 6 clients. Further observations revealed all 6 clients where up and dressed. Further observations revealed the HM was alone with the 6 clients unit 11:36am when the qualified intellectual disabilities professional (QIDP) came into the home. During an interview on 2/8/21, the HM stated the third shift staff had left the home "around"					8609 ST	ONEGATE DR		
CFR(s): 483.430(d)(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients: (i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2; (ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4; (iii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4; (iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4. This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility failed to assure adequate staff-to-client ratios were met. The finding is: During morning observations in the home on 2/8/21 at 9:55am, the home manager (HM) was alone in the home with 6 clients. Further observations revealed the HM was alone with the 6 clients until 11:36am when the qualified intellectual disabilities professional (QIDP) came into the home. During an interview on 2/8/21, the HM stated the third shift staff had left the home "around"	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
During an interview on 2/8/21, the QIDP revealed ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Direct care staff muthe following minimic clients: (i) For each define children under the aprofoundly retarded physical disabilities aggressive, assault manifest severely behavior, the staff to (ii) For each define serving moderately client ratio is 1 to 4 (iii) For each define serving clients who mild retardation, the staff to ratios were met. The During morning observations reveat dressed. Further of was alone with the the qualified intelled (QIDP) came into the During an interview third shift staff had 4:40am."	ust be provided by the facility in turn ratios of direct care staff to ed residential living unit serving age of 12, severely and diclients, clients with severe tive, or security risks, or who hyperactive or psychotic-like to client ratio is 1 to 3.2; ed residential living unit retarded clients, the staff to estaff to client ratio is 1 to 6.4. Is not met as evidenced by: tions and interview with staff, assure adequate staff-to-client the finding is: Servations in the home on the home manager (HM) was with 6 clients. Further led all 6 clients where up and observations revealed the HM 6 clients until 11:36am when citual disabilities professional the home. For on 2/8/21, the HM stated the left the home "around"		87			(Ye) DATE

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.

Facility ID: 955748

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G293	B. WING _		02/	09/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8609 STONEGATE DR RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
W 187	Continued From pa two staff are the mi up and dressed.	ge 1 nimum when all 6 clients are	W 18	37			
W 189	STAFF TRAINING CFR(s): 483.430(e)		W 18	39			
	initial and continuin	g training that enables the m his or her duties effectively,					
	Based on observatinterviews, the facil	s not met as evidenced by: iions, record review and ity failed to ensure staff were o call clients by their given g is:					
		s in the home on 2/8/21 at led a client "Boo" on three is.					
	6:39am, Staff D cal	s in the home on 2/9/21 at led a client "baby" five "my love" four separate times.					
	she was calling the to get them to do th Further interview re	on 2/9/21, Staff D revealed clients "baby" and "my love" ings during meal preparations. vealed Staff D was just trying the towards the clients.					
W 249	manager stated, "I	on 2/9/21, the program don't believe it's appropriate" g the clients anything else but	W 24	49			
	CFR(s): 483.440(d)	(1)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G293	B. WING			02	09/2021
NAME OF PROVIDER OR SUPPLIER STONEGATE				8609 S	T ADDRESS, CITY, STATE, ZIP CODE TONEGATE DR IGH, NC 27615	1 02	00/2021
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 249	formulated a client's each client must re- treatment program interventions and so and frequency to su	ge 2 rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the I in the individual program	W 2	49			
	This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 4 audit clients (#3) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plans (IPP) in the area of medication administration. The finding is:						
	home on 2/9/21 at 0 into the medication medications were a During immediate in had pre-punched cl medication cup. Fu "some years ago [O medications and to up in the hospital; s medications are pu Review on 2/9/21 o life assessment data	f client #3's community/home led 12/8/20 revealed he can					
	punches his won m	in his medication basket and edications into a cup, on 2/9/21, the program					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G293	B. WING		02	/09/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8609 STONEGATE DR RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 249 W 340	Continued From pa manager revealed opills for his own ind NURSING SERVIC CFR(s): 483.460(c)	client #3 should punch his own ependence.	W 2				
	Nursing services m other members of t appropriate protect measures that inclu	ust include implementing with he interdisciplinary team, ive and preventive health ude, but are not limited to staff as needed in appropriate					
	Based on observatinterview, the nursing that staff were sufficted temperature and as regards to COVID-	s not met as evidenced by: tions, record review and ng services failed to ensure ciently trained in taking the sking required questions in 19 protocol. This potentially nts in the home. The finding is:					
	2/9/21 at 5:28am, the Further observation	servations in the home on ne surveyor entered the home. ns revealed Staff B who d not take the temperature of					
	screening tool state equal to 100.0 F (3' following: muscle a sore throat, new of headache, loss of the past 14 days)? (Notemperature prior to traveled internation the last 14 days? Headache, loss of the past 14 days? Headache, loss of the past 14 days? Headache internation the last 14 days?	f the facility's home visitor ed, "Fever greater than or 7.8 C), and one or more of the aches, shortness of breath, changed cough, chills, aste or smell (new onset in the ote, we will be taking your o your visit today). Have you ally or on a cruise ship within have you or anyone in your se (within 6 feet) contact with					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G293		B. WING _		02	02/09/2021		
NAME OF PROVIDER OR SUPPLIER STONEGATE				STREET ADDRESS, CITY, STATE, ZIP CODE 8609 STONEGATE DR RALEIGH, NC 27615	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 340	COVID-19 (Coronar During an interview manager stated to o	ge 4 confirmed or presumed virus) within the last 14 days?" on 2/9/21, the program due safety measures during ly from the outside should	W 34	40			
W 368		ATION (1) g administration must assure Iministered in compliance with	W 36	68			
	Based on observat interview, the facility medications were a with physician's ord	s not met as evidenced by: ions, record review and y failed to ensure all dministered in accordance ers. This affected 1 of 4 audit d receiving medications. The					
	2/8/21 at 4:54pm, c	administration in the home on lient #6 consumed Amitiza At no time was client #6 eat.					
	signed 1/27/21 state	f client #6's physician orders ed, "Amitiza 24 MCG Take 1 by mouthwith a meal."					
W 382	manager confirmed something to eat whe capsule.	on 2/9/21, the program client #6 should have had nen he consumed his Amitiza AND RECORDKEEPING 2)	W 38	32			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G293	B. WING			02/0	09/2021
NAME OF PROVIDER OR SUPPLIER STONEGATE			STREET ADDRESS, CITY, STATE, ZIP CO 8609 STONEGATE DR RALEIGH, NC 27615	DDE		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTION :	SHOULD	BE	(X5) COMPLETION DATE
The facility must ke locked except wher administration. This STANDARD is Based on observations and the finding is: During observations A picked up the wat frozen. Further observations reveal for client #6 out on was in the room. During an interview he had been trained unattended. Review on 2/9/21 or revealed a noticed a states, "STONEGA'ENSURE THIS PLANOT IN USE."	ep all drugs and biologicals a being prepared for so not met as evidenced by: ions and interviews, the facility medications remained locked. Is in the home on 2/8/21, Staff for pitcher and noticed it was servations revealed Staff A nedication room, going into the per pitcher of water. Additional led Staff A left the medications the desk, while the surveyor on 2/8/21, Staff A confirmed do not to leave the medications of the medication closet which TE Medication closet which TE Medication closet when a con 2/9/21, the qualified es professional (QIDP)		382			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa The facility must ke locked except wher administration. This STANDARD is Based on observat failed to ensure all in the finding is: During observations A picked up the wat frozen. Further observations reveal for client #6 out on was in the room. During an interview he had been trained unattended. Review on 2/9/21 or revealed a noticed of states, "STONEGATENSURE THIS PLANOT IN USE." During an interview intellectual disabilities confirmed staff known.	ATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked. The finding is: During observations in the home on 2/8/21, Staff A picked up the water pitcher and noticed it was frozen. Further observations revealed Staff A walking out of the medication room, going into the kitchen to get another pitcher of water. Additional observations revealed Staff A left the medications for client #6 out on the desk, while the surveyor was in the room. During an interview on 2/8/21, Staff A confirmed he had been trained not to leave the medications unattended. Review on 2/9/21 of the medication room revealed a noticed on the medication closet which states, "STONEGATE Medication closet ENSURE THIS PLACE IS LOCKED WHENEVER NOT IN USE." During an interview on 2/9/21, the qualified intellectual disabilites professional (QIDP) confirmed staff know not to leave medications	A. BUILD 34G293 B. WING PROVIDER OR SUPPLIER ATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked. The finding is: During observations in the home on 2/8/21, Staff A picked up the water pitcher and noticed it was frozen. Further observations revealed Staff A walking out of the medication room, going into the kitchen to get another pitcher of water. Additional observations revealed Staff A left the medications for client #6 out on the desk, while the surveyor was in the room. During an interview on 2/8/21, Staff A confirmed he had been trained not to leave the medications unattended. 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WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER FERENCE ACTION SHOULD CROSS-REFERENCED FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED IN FERENCE DEFICIENCY) W 382 The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked. The finding is: During observations in the home on 2/8/21, Staff A picked up the water pitcher and noticed it was frozen. Further observations revealed Staff A walking out of the medication room, going into the kitchen to get another pitcher of water. Additional observations revealed Staff A left the medications for client #6 out on the desk, while the surveyor was in the room. 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