STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure outside services meet the needs of each client. This affected 1 of 4 audit clients (#2). The finding is: Review on 2/16/26 of client #2's Individual Program Plan (IPP) dated 12/12/25 revealed required 48/64 ounces of fluid daily measure and document each liquid at allotted time. Interview on 2/16/26 with Day Program Qualified Intellectual Disabilities Professional revealed she had no knowledge of a fluid restriction for client #2. Interview on 2/17/26 with the facilities Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 required fluid daily measure and document should be used at the day program to record the amount of liquid ingested.	W 120		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review, observations and interviews, the facility failed to ensure staff were sufficiently trained in the medication guidelines and feeding guidelines. This affected 1 of 4 audit clients (#2). The findings are:	W 189		

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

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W 189	Continued From page 1 Observations on 2/17/26 in the home during the medication pass at at 6:45am revealed, client #2 retrieved his medication box, punched medications poured water and ingested his pills. Record review on 2/17/26 revealed client #2 medication guidelines staff were to retrieve medication basket for client#2 and punch out medications into a pill cup, due to client behavior of ingesting to many of his medications and breaking in the medication closet. Interview on 2/17/26 with staff A revealed she was unaware of any medication guidelines for client #2. Interview on 2/17/26 with the qualified intellectual disabilities professional confirmed client #2 medication guidelines should have been followed during the medication pass.	W 189		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure each client	W 249		

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W 249	Continued From page 2 received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP). This affected 2 of 3 audit clients (#1). The finding is: Observation on 2/16/26 in the home at 5:30 pm during mealtime client #1 was leaned over to left in his kitchen table chair. Client #1 ate with his face in his plate with no prompts to sit back or sit up in his chair. Client #1 was given his whole portion size at one time not half at a time. Client #1 ate his food at a steady pace without prompts to take sips of his drink in between bites. Record review on 2/17/26 of client #1's mealtime guidelines dated 5/22/25 revealed his portion size should be split into halves. Offer him one half of the food that has been cut into bite size pieces at a time. Encourage alternating liquids and solids. Should encourage to eat at a slower pace while eating in efforts of decreasing chocking episodes. Interview on 2/17/26 staff B revealed she was unaware of feeding guidelines for client #1. Interview on 2/17/26 with the qualified intellectual disabilities professional confirmed that staff should adhere to the feeding guidelines for client #1.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and	W 368		

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W 368	Continued From page 3 interview, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 4 audited clients (#6). The finding is: Observations in the facility on 2/16/26 at 4:26pm, client #6 was observed ingesting Lubiprostone capsule 24 mcg. Client #6 ingested his medication with water. Further observation revealed client #6 beginning to eat dinner at 5:30pm Review on 2/17/26 of client #6's physician's orders dated 1/7/26 revealed an order for Lubiprostone 24 mcg, take 1 capsule by mouth twice daily with meals. Interview on 2/17/26 with the facility nurse confirmed the medication should have been given with meals.	W 368		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 4 audit clients (#1 and #3) received their specially prescribed diet as indicated. The findings are: A. Observations in the facility on 2/16/26 during dinner at 5:30pm revealed client #2 was served whole cheeseburger, whole vegetables. Further observations during breakfast on 2/17/26, client	W 460		

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W 460	Continued From page 4 #2 was served a whole slice of toast. Record review on 2/17/26 of client #2's physician orders dated 12/23/25 revealed coarsely chopped heart healthy low sodium diet. B.Observations in the facility on 2/16/26 during dinner at 5:30pm revealed client #3 was served whole cheeseburger, whole vegetables. Further observations during breakfast on 2/17/26, client #3 was served a whole slice of toast. Record review on 2/17/26 of client #2's nutritional evaluation dated 10/20/25 revealed regular diet cut/grind food. Interview on 2/17/26 with the facility nurse revealed client should receive their prescribed diets. Interview on 2/17/26 with the qualified intellectual disabilities professional confirmed clients should receive their prescribed diets.	W 460		