STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345506	A. BUILDING ______ B. WING ______	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	**700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407**

(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
F 000	INITIAL COMMENTS A unannounced complaint investigation was conducted. Event ID: PULV11. Exit date: 3/10/20. The 2 allegations were not substantiated. However, F609 was cited for reporting.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		4/7/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/26/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345506	A. BUILDING ______ B. WING ______	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	**700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407**

(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
F 609	Continued From page 1 Based on record review and staff interviews, the facility failed to report to the state an injury of unknown origin (significant injury) within the required 2-hour timeframe for 1 of 3 residents reviewed for abuse (Resident #1). Findings included: Resident #1 was admitted to the facility on 8/16/16 with the diagnoses of muscle weakness, chronic kidney disease, abnormal posture, and cerebral infarction. Resident #1 had care plans dated 2/7/20 for being severely impaired with cognitive decision making, required extensive assistance with activities of daily living, incontinence, skin integrity, safety awareness and falls. A quarterly Minimum Data Set dated 2/9/20 revealed the resident had moderate difficulty hearing. The resident was severely cognitively impaired. The resident had no behaviors and no rejection of care. The resident required extensive assistance with bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. He was independent with eating, and with locomotion off the unit. The resident required total dependence with bathing/showers. The resident was not steady when moving from a seated to standing position or with surface to surface transfers. The resident used a wheelchair and was always incontinent of urine and frequently incontinent of bowel. An incident report dated 2/28/20 revealed Resident #1 had a razorlike burn under his nose. The area was not assessed due to the resident eating. The incident report revealed the "area	F 609	The incident for this resident was reported although not in the required time frame. An audit will be done by 3/31/2020 of all incident reports for the past month to insure no injuries of unknown origin were unreported. Targeted inservicing to be done with the Director of Nursing, Administrator and nursing staff by the Staff Development Coordinator on the reporting requirements detailed in 483.12(c)(1)and also to immediately report any injuries of unknown origin to the Administrator or Director of Nursing. The Administrator will perform weekly audits beginning April 3, 2020, of incident reports turned in for the week to insure no injuries of unknown origin were unreported. The weekly audits will be conducted for one month and then monthly audits will be done for 3 months and then quarterly audits done and reported on as part of our Quality Assurance and Performance Improvement program	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345506	A. BUILDING ______ B. WING ______	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	**700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407**

(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
F 609	Continued From page 2	F 609		

swollen and slightly bruised." There was also blood noted in the resident's mouth. The resident was alert. The resident's power of attorney was notified via phone at 7:30 AM and a physical assessment was completed. The root cause analysis stated the resident may have bumped the side rail while turning.

A nursing note dated 2/28/20 revealed a bruise was noted to the top lip, under nose. No complaints, pain nor discomfort were voiced at this time. No signs or symptoms of distress were noted. The resident was "Unable to verbalize what happened at this time". Vital signs were stable. The power of attorney was contacted, and a message was left.

A police report dated 3/2/20 at 3:01 PM revealed the incident was found on 2/28/20 and the crime incident involved a simple assault (physical). Unknown tools/weapons were used, and the premise type was unknown.

An initial allegation report was submitted to the state on 3/2/20 at 1:08 PM. The date of the incident was 2/28/20 and the facility became aware of the incident on 2/28/20. It revealed the resident had bruising to his upper lip and a small cut under his upper lip. Nursing Assistant #1 was suspended on 2/27/20.

A 5-day investigation report was submitted to the state (via fax) on 3/5/20 at 3:25 PM. The alleged employee was Nursing Assistant #1. The incident occurred on 2/28/20 and the facility became aware of the incident on 2/28/20. An investigation was completed, which included staff interviews. The resident had an injury of unknown origin and harm. Law enforcement were notified on 3/2/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345506	A. BUILDING ______ B. WING ______	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407

(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
F 609	Continued From page 3	F 609		

The results of the allegation for suspicion of a crime was not substantiated but NA #1 was terminated. The allegation/incident type was an injury of unknown source.

The Administrator was interviewed on 3/10/20 at 9:43 AM. She stated they initially thought the resident hit his face on the siderail before she interviewed staff. The nursing staff thought the incident was an accident. The resident's family came in and were able to get more information out for the resident. The resident's story changed. Then that is when she completed the 24 hours report. She stated the resident's family came to the facility on Sunday 3/1/20 and on Monday 3/2/20, the family came to her office (about the resident's injury). The family stated what the resident was saying about being hit was accurate. She told the resident's family she was going to talk to the staff and was investigating it. That same day she (the family) called the police on 3/2/20. She completed her 5-day report on the 3/5/20. If a resident had a bruise of unknown origin, then she would report it. The resident wiggled in bed and got agitated. Sometimes the resident made a lot of noise at night. She stated on Friday the area was approximately less than ½ of an inch in size on the right side above his lip was red and swollen. It looked like a possible cut above his lip. The resident didn't want them to look it his mouth. She didn't notice any bruising to his hands/wrist. On Monday, the area had bruised under his nose and had small dots on the right side.

The Administrator was interviewed on 3/10/20 at 2:22 PM. She stated that she would report the injury (to the state) that day if she didn't have a reasonable explanation of what occurred.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345506	A. BUILDING ______ B. WING ______	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	**700 SOUTH HOLDEN ROAD** **GREENSBORO, NC 27407**

(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
F 609	Continued From page 4 The Administrator was interviewed on 3/10/20 at 2:38 PM. She stated she would expect for the regulations for reporting to be followed.	F 609		