North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0141	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitestone a Masonic and Eastern Star Community	**700 South Holden Road , Greensboro, North Carolina, 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
D0000	Initial Comments A complaint investigation survey was conducted from 2/04/2026 through 2/06/2026. Event ID# 1E36FE-H1. The following intake was investigated: 2641211. 1 of the 4 complaint allegations resulted in deficiency.	D0000		02/17/2026
D0367	Medication Administration CFR(s): 10A NCAC 13F .1004 (j) 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D0367	Disclaimer This plan of correction has been prepared and executed because the law requires it. This plan does not constitute an admission that any of the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and WhiteStone: A Masonic & Eastern Star Community reserves all rights to raise all possible contentions and defenses in any claim, action, or proceeding. Please accept the latest date on this plan of Correction as the written credible allegation of compliance for the deficiencies cited at WhiteStone: A Masonic & Eastern Star Community. D0367 It is the policy of WhiteStone: A Masonic & Eastern Star Community that our community will maintain accurate medical records for each resident. We submit that the facility will continue in this effort as follows. As it relates to correcting the observed deficiency associated with Resident #1: The inaccurate Ativan entry on Resident #1's MAR was immediately corrected. Resident #1 was assessed for any potential negative outcomes; no adverse effects were identified, as it was found that the resident did not receive the incorrect	03/07/2026

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

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D0367	Continued from page 1 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to maintain an accurate medical record when a medication aide documented Ativan was administered on the medication administration record (MAR) when it was not for 1 of 3 sampled residents reviewed for medication administration (Resident # 1). The findings included: Resident #1 was admitted to the facility on 8/9/19 with a diagnosis that included anxiety disorder and dementia. Physician order dated 9/7/22 indicated administer Resident #1 alprazolam (Xanax) tablet 1 milligram (mg) give 1 tablet by mouth (po) at bedtime for anxiety/insomnia. Physician order dated 8/29/23 indicated administer Resident #1 alprazolam tablet 0.5mg po in the morning for behaviors related to anxiety disorder. Review of Resident #1's physician order dated 9/29/23 stated administer lorazepam (Ativan) oral tablet 0.5mg po one time only related to anxiety disorder for one day. Review of the facilities order audit report indicated lorazepam (Ativan) oral tablet 0.5mg order was created by Nurse #1 on 9/29/23 at 9:39AM. Physician order dated 9/29/23 revealed lorazepam oral tablet 0.5mg po one time only related to anxiety disorder for one day was discontinued on 9/29/23. Resident #1's Medication Administration Record (MAR) for the month of September 2023 indicated she was administered Ativan 0.5mg on 9/29/23 at 9:54AM by Medication Aide #1. Medication Error report for Resident #1 dated 9/30/23 revealed a transcription error for Xanax 0.5mg tablet. The description of events stated, "Transcribed to electronic medication administration record (EMAR) Ativan 0.5mg x 1 dose. The medication to be given was Xanax 0.5mg x 1 dose". The event continued with Xanax was given as ordered, Ativan was never given. "No card of Ativan was on the cart, and no Ativan was pulled from the automated medication cart". The error was discovered by Nurse #1 on 9/29/23 and there were no adverse reactions documented. The interventions included staff were education on "rights of medication	D0367	Continued from page 1 medication. The Director of Nursing completed a Medication Transcription Error Report for Resident #1 to document the incident and ensure appropriate corrective actions were taken. The facility has established the following action steps in attempts to identify residents that might have been affected by similar conditions and to ensure compliance with the rule, On 2/27/2026, the Director of Nursing and Nursing Supervisors completed a lookback of 100% controlled substance entries for the last 30 days to identify any discrepancies. The results of this lookback revealed no issues. To prevent future problems associated with this rule the facility submits it will do the following: The Director of Nursing revised the "Medication Administration & Documentation" policy to explicitly require that staff document on the MAR only after observing the resident receive the medication and to prohibit pre-charting under all circumstances. The policy will also require reconciliation between MAR entries and automated dispensing cabinet transaction logs for one-time/PRN doses when questioned. All Registered Nurses, Licensed Practical Nurses, and Medication Aides will be provided education by the Staff Development Coordinator of the revised "Medication Administration & Documentation" policy. This education will be completed by 3/6/2026. This training will be included for all new hires that administer medications. All Registered Nurses, Licensed Practical Nurses, and Medication Aides will be provided education by the Staff Development Coordinator covering the eight rights of medication administration; prohibition of pre-charting; and proper management of one-time and PRN orders. This education will be completed by 3/6/2026. This training will be included for all new hires that administer medications.	

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D0367	Continued from page 2 administration". Interview with Medication Aide #1 on 2/5/26 at 11:01AM revealed she could not recall a specific date but did recall a situation in which she was reassigned with an agency nurse to administer medications to Resident #1. Upon review of Resident #1's September 2023 MAR, Medication Aide #1 confirmed she had initialed the MAR because she must have given Resident #1 Ativan 0.5mg. Medication Aide #1 indicated medications should not be signed on the MAR until administered. Medication Aide #1 stated she recalled Resident #1's family member being upset Resident #1 was administered Ativan. Medication Aide #1 revealed she recalled Resident #1's medications changing often and believed Resident #1 was always on Ativan. A telephone interview with Nurse #1 on 2/6/26 at 9:56AM revealed she previously worked at the facility. She could not recall the date but revealed she recalled an incident where Resident #1 had received Ativan that her family did not want her to have. She stated the only thing she recalled about the situation was there was an agency nurse assigned to the medication cart for the unit where Resident #1 resided. Nurse #1 indicated that nurses and medication aides should not document on the MAR until after the resident has been administered the medication. An interview with the previous Director of Nursing (DON) was conducted by phone on 2/6/26 at 10:29AM. She revealed she could not recall a specific incident involving Resident #1 receiving Ativan. The previous DON made a general statement indicating staff should not sign the MAR until the medication was given. Interview was conducted with the Administrator and the current DON on 2/6/26 at 3:30PM. The Administrator revealed Resident #1 did not receive Ativan 0.5mg but it was signed as given by Med Aide #1 on the September 2023 MAR as administered. The Administrator revealed a medication error report was completed 9/29/23 for Resident #1 regarding a transcription error for the administration of Ativan. He further revealed the facilities electronic medication machine audit report showed Ativan was not dispensed for Resident #1 and upon review of the facilities medication cart there was no Ativan pill blister packet for Resident #1. The Administrator and the current DON stated medications should not be signed on the MAR until the medication was administered.	D0367	Continued from page 2 To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will: The Director of Nursing or Nursing Supervisor will audit MARs five times a week for four weeks, three times a week for four weeks, and then once a week for four weeks. These audits will focus on one-time orders, PRNs, late entries, and any discrepancies. Findings, trends, and corrective actions will be logged on the "MAR Accuracy Audit Tool" and will be reported to the facility Quality Assurance Performance Improvement (QAPI) Committee by the Director of Nursing for review and to determine if further action is required. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 3/7/2026.	