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 03/05/2021

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
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E 004		4/5/21

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

Electronically Signed | 03/26/2021

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 004	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the Emergency Preparedness Plan (EPP) was maintained and updated yearly per regulation. Findings included: Review of the facility's EPP on 3/5/2021 revealed that their plan was dated for March 2019 and included key personnel names who no longer worked at the facility. During an interview on 3/5/2021 at 10:05 AM with the facility's Plant Operations Manager, he stated was unaware of any table-top exercises/reviews done in the past year that would have addressed updating the EPP as regulated. During an interview on 3/5/2021 at 10:45 AM with the Executive Director/Interim Facility Administrator, he stated that, although the facility had activated the EPP last year during the pandemic, the facility had not sat down and completed a formal update and review of the EPP within the year 2020 as required by regulation.	E 004	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 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 and Eastern Star Home. It is the policy of WhiteStone that the Emergency Preparedness Plan (EPP) is maintained and updated yearly per regulation. We submit that the facility will continue in this effort as follows; As it relates to the observed deficiency, the facility Director of Plant Operations will complete a review of the emergency preparedness and document updates for the facility's Emergency Preparedness Plan. The facility has updated the key staff directory outlined in the plan to reflect current facility personnel. Additionally, the facility has performed an updated risk assessment for the community and incorporated the assessment into the EPP. The Administrator will verify all EPP manuals are current, updated and accessible. Manuals are located at each nurse's charting room, Administrators Office, Plant Operations Office, and Front Reception Desk of the health center. The	

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E 004	Continued From page 2	E 004	facility will ensure ongoing compliance by offering annual staff in-services of the Emergency Preparedness Plan. The review of EP Plan will also be added into the facility's Safety Committee program on a monthly basis and results shared at QAPI meetings quarterly. To ensure the measures taken have been effective and that the deficiency remains corrected, the facility Plant Operations Director or designee will perform an audit of EP Plan and binder locations monthly for three months, then quarterly for 3 quarters, and annually thereafter. Findings will be reported to the Administrator and facility Quality Assurance Performance Improvement (QAPI) Committee for review and to determine if further action is required. Compliance will be achieved no later than April 5, 2021.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/2/21 through 3/5/21. 1 of the 7 complaint allegations was substantiated but did not result in a deficiency. Event ID# R2GC11	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the behavior section (Section E) on the Minimum Data Set	F 641	WhiteStone policies outline the importance of submitting accurate Minimum Data Set (MDS) assessments	4/5/21

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F 641	Continued From page 3 (MDS) assessment for 3 of 13 residents (Resident #11, Resident #14 and Resident #23) reviewed for MDS accuracy. Findings included: 1. Resident #11 was admitted to the facility on 12/11/18 with diagnoses that included, in part, dementia without behavioral disturbance and insomnia. The quarterly MDS assessment dated 12/22/20 revealed dashes were coded in the behavior section for the items of behavior symptoms, rejection of care and wandering. On 3/4/21 at 9:44 AM an interview was completed with MDS Coordinator #1. She stated the Social Services Assistant (SSA) was responsible for the completion of section E on the MDS assessment. MDS Coordinator #1 reviewed the assessment and explained the SSA coded behavior symptoms, rejection of care and wandering items with a dash which indicated, "no information." She added the SSA should have coded the items with 0, 1 or 2. During an interview with the SSA on 3/4/21 at 1:38 PM she explained she typically completed section E of the MDS assessment. She stated after she assessed Resident #11 she meant to code the behavior section with a "0," which indicated no behavior but mistakenly coded behavior symptoms, rejection of care and wandering items with a dash. The SSA said the inaccurate coding was a data entry error. A follow up interview was completed with MDS Coordinator #1 on 3/4/21 at 1:42 PM, during	F 641	timely for each resident. To ensure ongoing compliance, we outline the following procedures. The MDS Coordinator will ensure that assessments for residents #11, #14, and #24 are modified for accuracy and retransmitted. The MDS Coordinator will complete an audit of all MDS Assessments completed year to date to ensure accuracy. Any MDS assessments that are not completed, will be corrected and resubmitted. Findings from the audit will be reported to the Administrator during the next QAPI meeting. To audit ongoing compliance, all MDS assessments will be logged on shared MDS calendar. All MDS assessments will be checked for completion by MDS Coordinator prior to closing assessment. Any MDS sections that have not been completed and signed will be corrected prior to being locked and closed. If deficiencies are identified, the findings will be reported monthly by the MDS Coordinator to the Administrator during the community's Quality Assurance Performance Improvement (QAPI) meetings. On-going monitoring of MDS sections will continue weekly for one month, monthly for 6 months, and annually thereafter. Compliance will be achieved on or before April 5, 2021.	

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F 641	Continued From page 4	F 641		

which she reported she had not checked the MDS assessment manually for accuracy once all disciplines entered their coding. She said the computer program indicated when each section was completed and then she closed out the assessment.

The Executive Director was interviewed on 3/5/21 at 10:57 AM. He shared the facility was educating staff to ensure an MDS assessment was accurate and complete before the assessment was closed out. He said the MDS Coordinators needed to go through each section and verify accuracy and not depend on the computer system to indicate that the assessment was completed.

2. Resident #14 was admitted to the facility on 10/19/17 with diagnoses that included, in part, Alzheimer's disease, anxiety disorder and depression.

The quarterly MDS assessment dated 1/6/21 revealed dashes were coded in the behavior section for the items of behavior symptoms, rejection of care and wandering.

On 3/4/21 at 9:44 AM an interview was completed with MDS Coordinator #1. She stated the Social Services Assistant (SSA) was responsible for the completion of section E on the MDS assessment. MDS Coordinator #1 reviewed the assessment and explained the SSA coded behavior symptoms, rejection of care and wandering items with a dash which indicated, "no information." She added the SSA should have coded the items with 0, 1 or 2.

During an interview with the SSA on 3/4/21 at

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F 641	Continued From page 5	F 641		

1:38 PM she explained she typically completed section E of the MDS assessment. She stated after she assessed Resident #14 she meant to code the behavior section with a "0," which indicated no behavior but mistakenly coded behavior symptoms, rejection of care and wandering items with a dash. The SSA said the inaccurate coding was a data entry error.

A follow up interview was completed with MDS Coordinator #1 on 3/4/21 at 1:42 PM, during which she reported she had not checked the MDS assessment manually for accuracy once all disciplines entered their coding. She said the computer program indicated when each section was completed and then she closed out the assessment.

The Executive Director was interviewed on 3/5/21 at 10:57 AM. He shared the facility was educating staff to ensure an MDS assessment was accurate and complete before the assessment was closed out. He said the MDS Coordinators needed to go through each section and verify accuracy and not depend on the computer system to indicate that the assessment was completed.

3. Resident #23 was admitted to the facility on 1/26/18 with diagnoses that included, in part, non-Alzheimer's dementia, anxiety disorder and depression.

The annual MDS assessment dated 2/1/21 revealed dashes were coded in the behavior section for the items of behavior symptoms, rejection of care and wandering.

On 3/4/21 at 9:44 AM an interview was completed

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F 641	Continued From page 6 with MDS Coordinator #1. She stated the Social Services Assistant (SSA) was responsible for the completion of section E on the MDS assessment. MDS Coordinator #1 explained when the SSA coded behavior symptoms, rejection of care and wandering items with a dash it indicated, "no information." She added the SSA should have coded the items with 0, 1 or 2. A follow up interview was completed with MDS Coordinator #1 on 3/4/21 at 1:42 PM, during which she reported she had not checked the MDS assessment manually for accuracy once all disciplines entered their coding. She said the computer program indicated when each section was completed and then she closed out the assessment. During an interview with the SSA on 3/5/21 at 10:19 AM she explained she typically completed section E of the MDS assessment. She stated after she assessed Resident #23 she meant to code the behavior section with a "0," which indicated no behavior but mistakenly coded behavior symptoms, rejection of care and wandering items with a dash. The SSA said the inaccurate coding was a data entry error. The Executive Director was interviewed on 3/5/21 at 10:57 AM. He shared the facility was educating staff to ensure an MDS assessment was accurate and complete before the assessment was closed out. He said the MDS Coordinators needed to go through each section and verify accuracy and not depend on the computer system to indicate that the assessment was completed.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		4/5/21

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F 656	Continued From page 7 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 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.	F 656		

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F 656	Continued From page 8 (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 staff interviews and record review, the facility failed to develop a care plan that addressed discharge goals and plans for 1 of 1 resident (Resident #25) reviewed for discharge to the community. Findings included: Resident #25 was admitted to the facility on 12/15/20 with diagnoses that included, in part, generalized muscle weakness, asthma, hypertension and anemia. Resident #25 discharged home on 12/23/20. The admission Minimum Data Set (MDS) assessment dated 12/15/20 revealed Resident #25 had moderately impaired cognition. The comprehensive care plan, updated 12/14/20 did not include information that addressed discharge planning. On 3/3/21 at 1:41 PM an interview was completed with the Social Services Assistant (SSA). She stated she had not completed a care plan for Resident #25 that addressed discharge planning and typically had not added discharge care plans to the comprehensive care plans for residents in the facility. SSA added that the MDS Coordinators might have added discharge goals/plans to the comprehensive care plan but wasn't sure.	F 656	It is WhiteStone policy to ensure that discharge planning begins on admission for all residents. The below steps will be put in place to ensure this policy is upheld. The Social Services Assistant (SSA) will audit all current residents for discharge care plans. If identified, SSA or designee will update the comprehensive care plan to ensure discharge planning is in place. Findings will be discussed in next QAPI meeting. To ensure ongoing compliance, the SSA or designee will open a Discharge Care Plan for each new admission when appropriate. The SSA will implement a new discharge planning policy and checklist to ensure compliance moving forward. The community will utilize the IDEAL Discharge Planning policy and checklist to ensure compliance. To evaluate the effectiveness of the program, the SSA or designee will audit the Discharge Checklist for all new admissions and report findings each month for 3 months, then each quarter for 3 quarters, then annually thereafter. Findings will be reported to the Administrator and facility Quality Assurance Performance Improvement (QAPI) Committee for review and to determine if further action is required. The facility will reach compliance by April 5, 2021.	

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F 656	Continued From page 9 MDS Coordinator #1 was interviewed on 3/4/21 at 1:44 PM. She explained each discipline (including social services) wrote their own care plans that corresponded to the section of the MDS they completed. She said social services was responsible for discharge planning information on the care plan and should have completed a care plan that addressed Resident #25's discharge plans/goals. During an interview with the Executive Director on 3/5/21 at 11:04 AM he shared he was not aware that discharge planning needed to be included on the comprehensive care plan.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and	F 688	WhiteStone policy highlights the	4/5/21

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F 688	Continued From page 10	F 688		

staff interviews, the facility failed to provide services for range of motion for 1 of 3 residents (Resident #12) reviewed.

The findings included:

Resident #12 was admitted to the facility on 6/14/2018 with diagnosis that included muscle weakness, congestive heart failure, chronic pain syndrome and arthritis.

A review of the Minimum Data Set (MDS) dated 1/15/2020 indicated Resident #12 had intact cognition and required extensive assistance of one staff member with bed mobility, transfers, toileting and dressing. She required supervised assistance of one staff member for cueing in the area of walking in the room and facility corridor and was not steady when walking but was able to stabilize without human assistance. The Resident was coded to have no impairment of range of motion in the lower extremities.

A review of the MDS dated 10/2/2020 revealed Resident #12 required extensive assist of one person with walking in the room and facility corridor and was not steady when walking but was able to stabilize without human support. The Resident was coded to have no impairment of range of motion in the lower extremities.

A review of the most recent MDS assessment dated 2/15/2021 indicated Resident #12 had intact cognition. She required extensive assistance of two staff members with bed mobility, transferring, toileting and dressing. Walking was documented to occur less than one time during the 14-day lookback period and required two personal physical assistance.

importance of improving or maintaining range of motion and mobility levels for all residents of the community. The following steps will ensure that residents receive appropriate services to ensure range of motion and mobility goals are reached.
1. Resident #12 has been reevaluated by Director of Rehab (DOR) for skilled service needs. A new program will be developed by the DOR or designee and goals assessed. A Physical Therapy program was designed by the DPT on site on 3/9/21. The established program is to include standing tolerance, transfer safety and gait. Resident #12 will be seen 3 times a week to focus on seated strengthening exercises to increase functional strength in preparation for increased stability during transfers. The long-term goal for this resident is to establish a Functional Maintenance Program to maintain gains.
2. The DOR or designee will screen all residents for therapy services no later than April 5, 2021 to ensure appropriate services are administered. If appropriate, a therapy referral will be submitted. Findings from this audit will be reported in the facilities upcoming QAPI meeting.
3. To ensure ongoing compliance, the Director of Rehab will provide a copy of the Functional Maintenance Program referral to the Director of Nursing as each resident has been evaluated for an appropriate program. The Director of Nursing will then implement the appropriate program. Further, all direct care staff will be in-serviced on the internal therapy referral process to

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F 688	Continued From page 11 Walking was coded as not steady and only able to stabilize with human assistance. The Resident was coded to have impairment of range of motion in both lower extremities. On 03/02/21 at 2:34 PM an interview was conducted with Resident #12 and she revealed that she no longer received help with walking for exercise or weight bearing and that when she was discharged from therapy, in 2020, she was walking 100 feet in the hall. She stated she desired to walk with staff assistance. On 03/04/21 at 1:21 PM an interview was conducted with the Director of Rehab (DOR) services and she revealed that Resident #12 was last on the therapy case load, 6/4/2020 - 7/1/2020, for a decline in mobility. The resident was working with PT for sit to stand transfers, ambulation of 40 - 100 feet, exercises for the lower extremities and she required verbal cueing of staff to complete exercises. The discharge recommendations were for the resident to continue the exercises independently with staff cueing and to ambulate with recreational services. The DOR stated the discharge plans were discussed with the Resident and she agreed upon a transfer of gait program to participate late in the day, because the resident preferred evenings. Education was provided to staff regarding her performance and safety concerns. A personalized exercise chart and green stretch band was provided and hung in the room. The DOR added that due to a previous COVID outbreak and Resident hospitalization, the resident changed rooms and the exercise chart should have been moved with the resident. The DOR stated it was her expectation that the recommendations be carried out and care	F 688	prevent resident ROM decline. 4. To ensure the measures taken have been effective and that the deficiency remains corrected, the Director of Nursing will perform an audit of the Functional Maintenance Program twice weekly x 4 weeks then weekly x 2 weeks to ensure compliance with the programs. Compliance with the Functional Maintenance Program will be reported at each QAPI meeting by the Director of Nursing or designee for a minimum of three consecutive meetings. 5. The facility will reach compliance by April 19, 2021.	

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 12	F 688		

planned as recommended by the therapy staff or the staff should receive clarification orders from the primary care physician (PCP).

An observation occurred on 03/04/21 at 1:38 PM with the DOR and there was not an exercise chart or green exercise band, hanging in Resident #12's room.

On 3/04/21 at 2:01 PM an interview was conducted with Recreational therapist #1 and she revealed that the facility recreational therapist did assist Resident #12 with walking when she was discharged from physical therapy last July. She added that the Resident had a good participation record and walked in the evenings until December 2020. She stated that in December 2020 the facility discontinued recreational therapy as a preventative infection control measure due to a COVID 19 outbreak. She revealed that all of the residents had resumed recreational therapy once the facility had no positive COVID 19 test results. She added that Resident #12 was the only resident to not resume recreational therapy and walking with assistance of staff, due to her infection control isolation status. She revealed the Resident had a current diagnosis of shingles.

On 3/4/21 at 2:21 PM an interview was conducted with the infection control preventionist and she revealed that shingles would not prevent a resident from participating in range of motion or walking activities if the resident met the current CDC recommendation. She added that Resident #12 would require a bandage or shield over the crusted shingles area but with proper precautions the Resident could work with recreational therapy.

On 3/4/21 at 3:11 PM an interview occurred with

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	345506	A. BUILDING _____ B. WING _____	C 03/05/2021

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F 688	Continued From page 13 the Director of Nursing and she revealed the facility can accommodate or find a way to provide exercise and ambulation to a resident with isolation. She stated it was her expectation that staff report to her if a resident was not currently receiving therapy recommended by the therapy rehabilitation team and that the Physical therapist recommendations be added to the care plan as needed. She added that she had not been made aware that Resident #12 had not been placed back on the recreational therapy list and that the Resident would require a new physical therapy consult, which would be requested immediately.	F 688		