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 04/17/2025

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 000	Initial Comments A recertification and complaint investigation survey was conducted from 4/14/25 through 4/17/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #G7GL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/14/25 through 4/17/25. Event ID #G7GL11. The following intakes were investigated NC00225594, NC00223702, NC00226708, NC00223721, NC00229393 and NC00226725. 6 of the 20 allegations resulted in a deficiency.	F 000		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and emergency contact interviews, the facility failed to identify hearing aides were missing and investigate whether an appointment was needed	F 685	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	5/7/25

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

Electronically Signed | 05/05/2025

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F 685	Continued From page 1 to maintain hearing abilities for a resident with reported hearing difficulties for 1 of 1 resident reviewed for hearing (Resident #16). The findings included: Resident #16 was admitted to the facility on 12/3/19 with diagnoses that included cerebral infarction, unspecified dementia, and sensorineural hearing loss (hearing loss caused by damage to the inner ear or the nerve from the ear to the brain). The quarterly Minimum Data Set (MDS) assessment dated 1/6/25 revealed Resident #16 had severe cognitive impairment, and she was coded for moderate hearing difficulty and the use of hearing aids. The care plan revised on 4/13/22 and reviewed on 1/6/25 indicated Resident #16 had a care plan in place for having a communication/hearing impairment. The written interventions included providing the resident with hearing aids every day, placed in both ears daily. An observation was conducted on 4/14/25 at 11:35 AM with Resident #16. She did not have hearing aids in either ear. The resident was unable to respond to interview questions. One of Resident #16's emergency contacts was interviewed on 4/14/25 at 11:39 AM, and she stated Resident #16 entered the facility with two hearing aids, but they were lost at some point. She stated the facility replaced those hearing aids but then the hearing aids were lost again. The resident's contact stated she had weekly video call visits with Resident #16, and the hearing aids	F 685	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. It is the policy of WhiteStone: A Masonic & Eastern Star Community that our community shall assist all personnel and residents in safe-guarding their personal property. We submit that the facility will continue in this effort as follows. 1. As it relates to correcting the observed deficiency associated with resident 16: a. The facility's Social Worker completed a "Personal Item Lost Report" for the missing hearing aids on 4/17/2025. The missing hearing aids have been unable to be located, and the facility has initiated the process for replacing the missing hearing aids. The Resident's Responsible Party has been made aware and agrees with the plan for replacement. b. While the facility is in the process of replacing Resident 16's hearing aids, a communication board has been placed within Resident 16's room to assist with communication. 2. The facility has established the following action steps in attempts to	

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F 685	Continued From page 2	F 685		

made it easier for the resident to understand their conversations when she wore them in the past. The contact stated she had spoken with the Administrator about the missing hearing aids in the past, but she was unsure if there was a plan to replace them.

An interview was conducted on 4/16/25 at 1:49 PM with Nurse #2 who stated she had worked for the facility for six months and had never put hearing aids in for Resident #16. She stated she felt the resident usually understood her.

On 4/17/25 at 9:25 AM, an interview was conducted with Nurse #3 who stated she had never seen or applied any hearing aids for Resident #16. Nurse #3 checked the medication storage room where she stated all hearing aids were cleaned and charged overnight for residents who used them but was unable to locate a storage pouch with Resident #16's name or label. She also checked the medication cart for the 300 hall where Resident #16 resided, but did not find any hearing aids stored in it. She also searched in Resident #16's room but did not locate any hearing aids.

An interview was conducted with the Director of Nursing (DON) on 4/17/25 at 10:32 AM. She indicated she was unaware Resident #16's hearing aids were an issue until that day. She stated she would have the NAs search for the hearing aids and would contact the resident's family if they were not found. She stated the facility would replace the hearing aids if they were not found.

The Administrator was interviewed on 4/17/25 at 12:08 PM, and he stated he was unaware

identify residents that might have been affected by similar conditions and to also ensure compliance with the rule,
a. All other Residents with orders for hearing aids were audited by the Director of Nursing and/or Designee on 5/2/2025 to verify that they are accounted for. The results of this audit showed that all the other hearing aids were accounted for.

3. To prevent future problems associated with this rule the facility submits it will do the following:
a. All Staff (FT, PT, PRN, and Agency) will receive education by the Administrator and/or Designee on the Center's Missing/Lost Item Policy to include the completion of the "Personal Item Loss Report" when any missing/lost item is identified. Staff will be educated on where to locate the "Personal Item Loss Report", how to complete the form, and who the form should be returned to. Any missing items will be added to the facility's 24-hour report for consistent follow-up. This education will be added to the facility's new staff orientation, annual staff training, and as needed. Any staff that have not received the education by the stated date of compliance will be required to receive the education prior to their next scheduled shift.

4. To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will audit the facility's 24-hour report five days a week for four weeks, three days a week for four weeks, and once a week for four weeks to

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F 685	Continued From page 3 Resident #16's hearing aids were missing until that day when the DON brought it to his attention. He stated he contacted the family to work on the replacement of the hearing aids. He further stated if the staff had been unable to locate Resident #16's hearing aids they should have brought it to the attention of the DON for a replacement.	F 685	ensure that all Missing/Lost Items are identified and resolved. 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. 5. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 5/7/2025.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and Medical Director, family member, and staff interviews, the facility failed to utilize a sit to stand lift per manufacturer's instructions which resulted in the sling slipping up and causing extensive bruising to Resident #399 under the resident's left arm, left side, and across her breast. Resident #399 was prescribed an anticoagulant (blood thinner) daily for atrial fibrillation (irregular and often rapid heart rhythm that can lead to blood clots in the heart). The following day Resident #399 experienced a syncopal episode (temporary loss of consciousness due to a sudden,	F 689	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	5/7/25

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F 689	Continued From page 4 temporary drop in blood flow to the brain) and when assessed it was noted she had low blood pressure and an irregular pulse. Resident #399 was evaluated in the emergency department and the physician documented the syncope was likely related to dehydration and acute blood loss anemia and was possibly worsened by atrial fibrillation with rapid ventricular rate (RVR). She was hospitalized for six days and required one unit of packed red blood cells (PRBC) due to a low hemoglobin (Hgb) (a protein in red blood cells that carries oxygen from your lungs to the rest of your body). The facility also failed to investigate the cause of the bruising and failed to have the manufacturer's manual for the sit to stand mechanical lift utilized by the facility. This deficient practice was for 1 of 6 residents reviewed for supervision to prevent accidents (Resident #399). The findings included: The manual for the sit to stand mechanical lift the facility utilized during stand strength trailing with Resident #399 was not provided by the facility. Per the manufacture's website, manufactures guidelines for the sit to stand mechanical lift, dated 11/2014, read in part: - Intended to be used on a horizontal surface for raising to a standing position and short transfer of residents in hospitals, nursing homes or other health care facilities where the resident has been clinically assessed to correspond to the following categories: · Sits in a wheelchair.	F 689	credible allegation of compliance for the deficiencies cited at WhiteStone: A Masonic & Eastern Star Community. It is the policy of WhiteStone: A Masonic & Eastern Star Community that to protect the safety and well-being of staff and residents, and to promote quality care, this community uses appropriate techniques and devices to lift and move residents. We submit that the facility will continue in this effort as follows. 1. As it relates to correcting the observed deficiency associated with resident 399: a. Resident 399 discharged from the facility on 10/22/2024 therefore no further corrective action can be taken. 2. The facility has established the following action steps in attempts to identify residents that might have been affected by similar conditions and to also ensure compliance with the rule, a. A thirty-day lookback audit was completed on all other Residents that utilize mechanical lifts by the Director of Nursing and/or Designee on 5/2/2025 to verify that the correct mechanical lift was being utilized to the manufacturer’s instructions and to ensure that there were no associated negative outcomes related to mechanical lift usage. The results of this audit showed that all other Residents were utilizing the correct mechanical lift and there were no associated negative outcomes related to mechanical lift usage. 3. To prevent future problems associated	

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F 689	Continued From page 5 · Is able to partially bear weight on at least one leg. · Has some trunk stability. · Dependent on carer in most situations. · Physically demanding for carer. · Stimulation of remaining abilities is important. - The equipment must be used for its intended purpose only and is operated within the published limitations. -intended to be used with clip slings only -except for the ' Transfer Slings ' which also have loops for attachment of the leg flaps to the central lug situated on the resident support arms. - Warning: Use only the sit to stand designated parts to avoid injuries attributable to the use of inadequate parts. Unauthorized modifications or repairs may affect its safety. Resident #399 was admitted to the facility on 07/09/24 with diagnoses that included mechanical complications of internal fixation device of bone of left lower leg (a surgical implant, such as a screw, plate, or rod, used to stabilize and maintain the alignment of broken bones during the healing process), physical deconditioning, anemia, atrial fibrillation with rapid ventricular rate (RVR). and obesity. Review of Resident #399's orders for September 2024 revealed the following order: Rivaroxaban (anticoagulant- decreases the clotting ability of the blood), Oral Tablet 20 MG, give 20 mg by	F 689	with this rule the facility submits it will do the following: a. All Nurse, Certified Nurse Aides (CNAs), and Therapy Staff (FT, PT, PRN, and Agency) will receive education on mechanical lifts by the facility's lift manufacturer, the Director of Nursing, and/or Designee. This education will include the proper utilization of mechanical lifts, techniques, and a competency checkoff to verify understanding of materials. This education will be added to the facility's new staff orientation, annual staff training, and as needed. Any staff that have not received the education by the stated date of compliance will be required to receive the education prior to their next scheduled shift. b. The manufacturer's manual for each mechanical lift has been provided to the Therapy and Nursing Departments as a reference guide. These manual's have been placed at each Nurses' Station and the Therapy Gym. c. All Nurses and CNAs (FT, PT, PRN, and Agency) will receive education by the Director of Nursing and/or Designee on the requirements for investigation of any reported skin changes/discoloration including those derived from mechanical lift utilization. This education will be added to the facility's new staff orientation, annual staff training, and as needed. Any staff that have not received the education by the stated date of compliance will be required to receive the education prior to their next scheduled shift.	

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F 689	Continued From page 6 mouth in the evening related to atrial fibrillation, give with supper. Resident #399 received daily until 09/24/24. Resident #399's admission Minimum Data Set (MDS) assessment dated 07/14/24 indicated she was cognitively intact. She was dependent on staff for all transfers by staff to sit to lying/lying to sitting and weighed 233 pounds. Resident #399 was also coded as receiving an anticoagulant. Resident #399's care plan, dated 07/09/24, included a focus that indicated she had the potential for injury related to mechanical lift use. No interventions were included. Another focus revealed Resident #399 was receiving anticoagulant medication. The interventions included for staff to obtain labs as ordered and report abnormal lab results to the physician, staff to monitor/document/report to physician any signs or symptoms of anticoagulant complications to include bruising, sudden changes in mental status, and significant or sudden changes in vital signs. Review of physical therapy (PT) note dated 09/04/24 at 5:16 PM, written by Physical Therapist #1 revealed she discussed trialing of the sit to stand lift to facilitate weight bearing through bilateral extremities and increase functional tolerance. Family member and Resident #399 agreeable to transfer training with the sit to stand lift. Physical Therapist #1 directed Resident #399 in static sitting at edge of bed (EOB) with maximal assistance initially to facilitate forward trunk lean but supported with bilateral upper extremity support on the sit to stand lift. Resident #399 directed in attempted standing with sit to stand lift times four trials with	F 689	4. To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will: a. Audit five staff members utilization of mechanical lifts weekly for four weeks, three staff members weekly for three weeks, and one staff member weekly for four weeks to verify proper techniques and devices. 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. b. Interview five staff members understanding of reporting and investigation requirements for skin changes/discoloration for four weeks, three staff members weekly for three weeks, and one staff member weekly for four weeks to verify proper techniques and devices. 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. 5. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 5/7/2025.	

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Resident #399 unable to clear buttocks from EOB due to pain to bilateral knees during each attempt.

Review of Physical Therapy (PT) notes for Resident #399 dated 09/05/24, 09/09/24, 09/11/24, 09/12/24, 09/13/24, 09/17/24, and 09/18/24 revealed Physical Therapists #1 utilizing the sit to stand lift for stand strengthening.

Review of physical therapy (PT) note dated 09/23/24, written by Physical Therapist #1 revealed Physical Therapist #1 instructed Resident #399 in supine (lying flat on back with face upwards) to sit with moderate assistance x 2 people. Physical Therapist #1 directed in static sitting at edge of bed requiring moderate assistance to correct posterior lean when supported. Physical Therapist #1 instructed Resident #399 to transfer from bed to wheelchair using the sit to stand mechanical lift followed by standing tolerance using the sit to stand mechanical lift and an additional support strap at her buttocks to achieve full upright posture. Resident # 399 tolerated 15 minutes and 17 seconds.

An interview was conducted on 04/16/25 at 10:15 AM with the Community Rehabilitation Director. She verified Resident #399 was on the therapy case load for strengthening after a hospitalization for surgical ankle repair. She stated Resident #399 did have lower extremity impairments and her overall strength was diminished due to deconditioning and that the Nursing Assistants (NAs) used the mechanical lift for all transfers. The Community Rehabilitation Director indicated Resident #399 did not want to go to the therapy gym and that the therapist would do her

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treatments in her room.

A follow up interview was conducted on 04/16/25 at 2:17 PM with the Community Rehabilitation Director. She explained residents were normally brought to the therapy gym for stand strengthening using the parallel bars and/or the standing frame. She stated Resident #399 did not want to go to the therapy gym and Physical Therapist #1 thought of using the sit to stand with an additional strap under her buttocks to aid in keeping her in the standing position for stand strengthening. The Community Rehabilitation Director verified there was no written therapy plan for utilizing the sit to stand lift for stand strengthening training for Resident #399. She verified the added strap was not recommended by the manufacturer's guidelines. She indicated Occupational Therapist (OT) #1 assisted Physical Therapist #1 with the treatment. The Community Rehabilitation Director also explained that she was made aware at the beginning of 09/2024 by Physical Therapist #1 that she was going to try utilizing the sit to stand lift for stand strength training on Resident #399, however she could not recall the specific date. She stated she trusted Physical Therapist #1 and supported her decision to use the sit to stand lift with the additional strap for stand strengthening training. The Community Rehabilitation Director indicated she personally would not use the sit to stand lift for stand strengthening, as it was intended to transfer residents, not for strengthening. She explained she was made aware by Physical Therapist #1 of the bruising to Resident #399's breasts, side, and under her arms caused by the sling sliding while Physical Therapist #1 utilized the sit to stand lift on 09/23/24 after Resident #399 was sent to the emergency room on 09/24/24.

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F 689	Continued From page 9	F 689		

Review of nursing note dated 09/24/24 at 12:44 PM written by Nurse # 2, revealed Resident #399 had an area of bruising noted on her left side, underneath her left arm, and breast area. The bruise was possibly caused by an apparatus used by physical therapy on 09/23/24. The area was examined by the Unit Manager and Nurse Practitioner (NP) #1 was notified. The area was also examined by Occupational Therapist #1.

A phone interview was conducted on 04/16/25 at 8:17 PM with Nurse #2. She explained that Resident #399's family member came to her on 09/24/24 and told her Resident #399 was complaining of pain under her arms and on her left side. Nurse #2 stated upon assessment of the areas she noted extensive bruising under residents left arm, left side, and across her breast. The family member told Nurse #2 that staff had used the sit to stand lift for stand strengthening on 09/23/24 and that the sling slipped and that was what caused the extensive bruising. She indicated she immediately reported the bruising to the Clinical Care Coordinator and Nurse Practitioner #1 (NP) who went in to assess Resident #399. NP #1 gave no orders at that time other than to monitor Resident #399. She also stated Resident #399 did not get out of bed often and that her legs were on the bigger side which made it hard for her to use them. After the incident the PT department did not use the lift with her again. Nurse #2 indicated Resident #399 could not stand unassisted at all, and nursing assistants (NAs) used the mechanical lift for all transfers with Resident #399. Nurse #2 did not recall if she completed an incident report.

Nurse Practitioner (NP) #1 did not document the

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assessment and was not available for interview.

Review of physical therapy (PT) note dated 09/24/24, written by Physical Therapist #1 revealed Resident #399 with new bruising to left upper flank, possible due to pressure from sit to stand mechanical lift sling. Nursing requested PT to withhold sit to stand treatment training at this time. Resident #399 required maximal assistance to maintain unsupported sitting due to heavy posterior lean. Resident #399 sat on edge of bed less than 2 minutes prior to exhibiting unresponsive episode. Resident was left with OT to monitor while PT immediately notified nursing who came and assessed vital signs. Resident #399 was left with nursing and ultimately ended up getting sent to the emergency room.

Attempts to reach Physical Therapist #1 by phone were not successful.

Attempts to reach Occupational Therapist #1, who no longer worked at the facility, were not successful.

Review of nursing note dated 09/24/24 at 9:35, written by Nurse #6 revealed Resident #399 had a syncopal episode while working with PT. Nurse Practitioner#1 and Unit Manager assessed resident at bedside. Stated blood pressure was "soft", and pulse was elevated and irregular. Emergency medical services were called. Resident #399 was gray and had fine tremors noted while on stretcher.

Attempts to reach Nurse #6 by phone were not successful.

Record review revealed vital signs, dated

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WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407

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09/24/24 at 3:30 PM (time of syncope episode) was blood pressure 90/50, blood sugar 285, pulse irregular, and respirations 16.

An interview was conducted on 04/17/25 at 8:35 AM with the Unit Manager. She stated she worked Monday through Friday, and no one had reported an incident on 09/23/24 related to the sit to stand lift and the sling sliding up on Resident #399. She was made aware of the bruising on 09/24/24 by Nurse #2 and upon observation of the area she noted very extensive bruising to Resident #399's left side, under her arms, and her breast. She did not fill out an incident report because Physical Therapist #1 indicated the incident with the sling slipping occurred with Physical Therapist #1, and she assumed they had reported it to the Director of Nursing. The Unit Manager verified she did assist Nurse Practitioner #1 with assessing Resident #399 when her blood pressure dropped after sitting up on the side of the bed with PT, and she passed out. She stated NP #1 gave the order to send Resident #399 to the emergency room for evaluation. She indicated Nursing Assistants (NAs) used the mechanical lift for all transfers with Resident #399.

A phone interview was conducted on 04/15/25 at 11:42 AM with Resident #399's family member. He explained on 09/23/24 he observed staff utilizing the sit to stand lift to aid with stand strengthening with Resident #399, after 15 minutes of being in a semi standing position, the sling around her slipped up, and she complained that the sling was hurting her under her arms. He indicated the sling was wrapped around Resident #399's torso and it had 2 buckles that were fastened in the front under her breasts. The sling hooks were connected to the lift at the handles

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where the slots were located. The additional strap was hooked in the same area as the sling connections, and it went across her buttocks, there was a pillow between her buttocks and the strap. Resident #399 was then lowered back down to her bed. He stated when he arrived at the facility on 09/24/24 Resident #399 was complaining of pain under her arms and to her breast areas. The family member explained he looked at the areas and observed extensive bruising under her arms, her left side, and her breasts. He then stated he notified Nurse #2 to make her aware. He stated he took pictures of Resident #399 in the sit to stand lift, she had a pillow under her buttocks and the additional strap on top of the pillow. He also had pictures of the extensive bruising to her breasts, under her arms, and down her side. The family member provided copies of the pictures he had taken which were reviewed by this surveyor.

Review of hospital discharge summary dated 09/30/24 revealed Resident #399 was brought to the emergency department on 09/24/24 after suffering a syncopal episode. At the time her blood pressure was 91/50. In the emergency department she was found to be tachycardic (high pulse) with heart rates 118-143 beats a minute. Resident #399's hospital course description included syncope was likely related to dehydration and acute blood loss anemia and possible worsened by atrial fibrillation with rapid ventricular rate (RVR). Extensive bruising/bleeding into the skin under left arm-acute blood loss anemia. Due to use of anticoagulant as well as lift at facility which appears to secure under the arms-holding anticoagulant for now. On 09/24/24 Resident #399's hemoglobin (Hgb) was 10.6 (normal range

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of Hgb 12.0-16.0), 09/25/24 Hgb 8.7, and on 09/26/24 Resident #399's Hgb dropped to 7.0 and required a blood transfusion of 1 unit of packed red blood cells (PRBC). Resident #399's Hgb was 8.2 on 9/27/24. It was noted Resident #399's Hgb was trending upward at the time of discharge and to continue to hold anticoagulant for now and recheck hemoglobin in 3-5 days. Permanent atrial fibrillation with acute RVR likely driven by volume depletion/acute blood loss and diagnoses with urinary tract infection. Disposition: Discharge back to skilled nursing facility (SNF) for rehabilitation stay.

Hospital discharge orders included restarting previous medications with the following exceptions. Furosemide 20 milligram (mg) by mouth daily-start on 10/01/24 (note dosage change), rivaroxaban (anticoagulant) 20 mg by mouth daily with supper (start taking on 10/07/24), and recheck Hgb in 3-5 days.

Review of Medical Director note dated 10/03/24 revealed Resident #399 was sent to the emergency room on 09/24/24 and discharged to our facility on 09/30/24 due to a syncopal episode (a temporary loss of consciousness, also known as fainting). Resident #399 was noted to have extensive bruising/bleeding into the skin under left arm, right arm with blood loss anemia. Resident #399 was transfused 1 unit of packed red blood cells (RBC), and her anticoagulant was held. During physical examination Resident #399 was awake and oriented, did not look in any distress. Vital signs: temperature 97.6, blood pressure 120/72, heart rate 70, respiratory rate 18, and saturation 96% on room air. Lungs clear, no wheeze or rales, abdomen soft, nontender, extremities with no pedal edema and

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neurologically no focal neurological sign.

An interview was conducted on 04/17/25 at 8:45 AM with the Director of Nursing (DON). She verified therapy was using the sit to stand mechanical lift with Resident #399 for stand strengthening. She stated that Physical Therapist #1 was the only therapist that used the sit to stand lift for stand strengthening and Resident #399 was the only resident that received stand strengthening with the sit to stand mechanical lift. The DON explained that she was unaware of this prior to 09/24/24 and was informed the day Resident #399 was sent to the emergency room. She explained after Resident #399's transfer to the hospital, she was asking the nursing staff why Resident #399 was being sent out to the hospital. Physical Therapist #1 told her (DON) she utilized the sit to stand mechanical lift with an additional strap positioned under Resident #399's buttocks for stand strengthening on 09/23/24 and the sling strap slid up some causing her to lower Resident #399 back down to the bed. Physical Therapist #1 told the DON she was unaware that the sling caused any trauma until the husband brought it to the staff's attention on 09/24/24. The DON indicated it wasn't until the next day that a family member reported to nurse#2 that the resident had pain and bruising under her arms and side. The DON verified the added strap was not recommended by the manufacture's manual guidelines. Nursing Assistants (NAs) used the mechanical lift for all transfers with Resident #399.

An interview was conducted on 04/17/25 at 8:45 AM with the Director of Nursing (DON). She stated she was made aware of the bruising to Resident #399's torso that was caused by the

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F 689	Continued From page 15 sling sliding after Resident #399 was sent to the emergency room on 09/24/24. The DON indicated an incident report, and an investigation should have been completed. The DON provided a manufacturer's manual for a sit to stand mechanical lift utilized by the facility, the manual provided was the incorrect manual for the specific sit to stand mechanical lift that was utilized with Resident #399. An interview was conducted on 04/17/25 at 11:25 AM with the Medical Director. He stated he was not aware that therapy was utilizing the sit to stand lift for stand strengthening and he had never heard of anyone doing that. He indicated according to the hospital records Resident #399 had an episode of syncope after therapy had sat her up on the side of the bed and her blood pressure dropped. He explained that bruising could cause acute bleeding, dropping the hemoglobin (Hgb), if the bruising was bad enough, however, he did not think this was the case with Resident #399. He further explained that Resident #399's blood pressure ran on the lower side, and he believed when Psychical Therapist #1 sat her up on the side of the bed she had a period of orthostatic hypotension (a sudden drop in blood pressure when you sit up after lying down) which caused her to black out. The Medical Director then stated Resident #399's Hgb dropped because of the blood draws she was getting during the hospital stay.	F 689		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		5/7/25

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processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 758	Continued From page 17 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Pharmacy Consultant, Medical Director and staff, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication (Resident #42). This was for 1 of 5 residents whose medications were reviewed. The findings included: A review of Resident #42's medical record revealed a hospital discharge summary dated 2/25/25 that included an order for Seroquel (an antipsychotic medication) 25 milligrams (mg) take a half tablet by mouth at bedtime. Resident #42 was admitted to the facility on 2/25/25 with diagnoses that included a history of a stroke. A review of the physician orders for Resident #42 included the following: - An order dated 2/25/25 for Seroquel 25mg take half a tablet by mouth at bedtime for anxiety. This order was changed on 3/6/25. - An order dated 3/6/25 for Seroquel 25mg one tablet by mouth at bedtime for anxiety. An admission Minimum Data Set (MDS) assessment dated 2/28/25 indicated Resident #42 was cognitively intact and received 7-days of an antipsychotic medication during the assessment period.	F 758	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. It is the policy of WhiteStone: A Masonic & Eastern Star Community that residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. We submit that the facility will continue in this effort as follows. 1. As it relates to correcting the observed deficiency associated with resident 42: a. On 4/17/2025, Resident 42's order for quetiapine was discontinued by the facility's Nurse Practitioner.	

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F 758	Continued From page 18 A review of the February 2025, March 2025, and April 2025 Medication Administration Records (MARs) indicated Resident #42 received Seroquel at bedtime as ordered. The Director of Nursing (DON) was interviewed on 4/16/25 at 3:50 PM and reviewed Resident #42's active physician orders. She confirmed the diagnosis for Seroquel use was anxiety and stated that it was not an appropriate clinical indication. On 4/17/25 at 9:25 AM, an interview was conducted with Nurse #1, who entered the increase in dosage for Seroquel on 3/6/25. She stated she was unaware that a diagnosis of anxiety was not an appropriate clinical indication for the use of Seroquel. On 4/17/25 at 9:37 AM, an interview occurred with the Unit Manager who entered the admission orders on 2/25/25. She reviewed the order and stated she was aware that anxiety was not an appropriate clinical indication for the use of Seroquel. She further stated that she should have found an appropriate diagnosis in the hospital discharge summary or contacted the physician to get an appropriate diagnosis. She felt it was an oversight. A phone interview was conducted with the Pharmacy Consultant on 4/17/25 at 9:53 AM. She was able to review her monthly drug regimen reviews for Resident #42 and stated that on 3/2/25 she requested for the physician to provide a qualifying diagnosis for the Seroquel that was used at bedtime.	F 758	2. The facility has established the following action steps in attempts to identify residents that might have been affected by similar conditions and to also ensure compliance with the rule, a. A thirty-day lookback audit was completed on all Residents with orders for antipsychotic medications by the facility's Nurse Practitioner on 5/2/2025 to verify that they were clinically indicated and necessary to treat a specific condition documented in the medical record. The results of this audit showed that all other Residents receiving antipsychotics had clinical indication documented in the medical record. 3. To prevent future problems associated with this rule the facility submits it will do the following: a. All Nurses, Physicians, and Nurse Practitioners (FT, PT, PRN, and Agency) will receive education from the Director of Nursing and/or Designee regarding the regulations on antipsychotic medications, the need for a clinical indicator for use, and the documentation required in the Resident's medical record. This education will include that any antipsychotic medication that is identified as not having an appropriate clinical indication for use will be reviewed with the Resident's Physician for additional direction. This education will be added to the facility's new staff orientation, annual staff training, and as needed. Any staff that have not received the education by the stated date of compliance will be required to receive the education prior to their next scheduled	

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F 758	Continued From page 19 An interview occurred with the Medical Director on 4/17/25 at 10:22 AM. He reviewed Resident #42's medical record and indicated when he was admitted to the facility on 2/25/25, the diagnosis of anxiety was chosen inadvertently. He stated he was aware that a diagnosis of anxiety was not an appropriate clinical indication for the use of Seroquel and stated that the order should have been clarified at the time of admission.	F 758	shift. 4. To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will audit all antipsychotic medications in the Morning Clinical Meeting daily for four weeks, three times a week for four weeks, and once a week for four weeks to ensure that each antipsychotic medication is clinically indicated and necessary to treat a specific condition. 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. 5. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 5/7/2025.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, Medical Director, Pharmacy Consultant and Resident Representative interviews, the facility failed to ensure a resident was free of significant medication error when Resident #14 received 2 units of Humalog insulin (short acting insulin/antidiabetic medication). Humalog insulin was not prescribed to Resident #14. On 10/26/25 Resident #14 was given Humalog insulin	F 760	Past noncompliance: no plan of correction required.	

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medication prescribed to another resident. This deficient practice affected 1 of 1 resident reviewed for significant medication error.

Findings included:

Resident #14 was admitted to the facility on 09/22/24 with diagnosis that included hypertension, hyperlipidemia, major depressive disorder, dysphagia, left shoulder pain and macular degeneration.

Resident #14's quarterly Minimum Data Set (MDS) dated 01/16/25 revealed she was cognitively impaired, and did not receive any insulin.

Review of medication related incident report dated 10/26/24 indicated that Nurse #5 had administered 2 units of Humalog Insulin to the wrong resident (Resident #14). Report also revealed that Nurse #5 had checked the blood glucose levels for Resident #14, and it was 195 and administered 2 units of Humalog Insulin to Resident #14. Report further indicated that Nurse #5 had given insulin to the wrong resident. Report also indicated that medical provider and resident representative were notified and that no harm occurred to Resident #14. Report also revealed that medical provider orders for Resident #14 was to have blood glucose levels checked once a day for three days.

Multiple attempts made to reach Nurse #5 for an interview were unsuccessful.

An interview conducted with Resident Representative (RR) on 04/15/25 at 12:50 pm, revealed that on 10/26/24 Resident #14 received

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insulin from Nurse #5. RR indicated that Resident #14 did not have an insulin order and did not have diabetes. RR also revealed that Nurse #5 did report to her (RR) the significant medication error. RR further stated that Nurse #5 acknowledged that he had given Resident # 14, 2 units of insulin at about 11:30 am. RR confirmed that Resident #14 did not have any adverse reactions and was not affected by the insulin. RR indicated that Nurse #5 was very forth coming and had notified medical provider. RR also confirmed that Resident #14 had a blood sugar level checked and her levels were never below normal.

Interview with Director of Nursing (DON) was conducted on 4/16/25 at 11:00 am. DON indicated that on 10/26/24, Nurse #5 administered 2 units of Humalog insulin to Resident #14 . DON confirmed that Nurse #5 had administered the 2 units to the wrong resident (Resident #14) . DON further stated that Nurse #5 did not identify Resident #14 and thus made the medication error. DON further revealed that Nurse #5 did notify the medical provider, RR, and DON. DON indicated that new orders were received to check the blood glucose levels for Resident #14 once a day for three days. DON confirmed that Resident #14 did not have any negative outcomes or adverse reactions from receiving the insulin, and in fact Resident #14 blood glucose levels remained 150. DON indicated that Nurse #5 no longer worked at the facility, but did receive immediate education after medication error , together with all other nurses and medication aides who were currently working at the facility.

Interview with Pharmacy Consultant was

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conducted on 4/16/25 at 12:30 pm. Pharmacy Consultant indicated that DON notified her of the medication error. Pharmacy Consultant indicated that she conducted random medication observation on several nurses over different shifts and units, multiple routes of administration to include subcutaneous (insulin injections) and no medication errors were observed.

Interview with Medical Director was conducted on 4/17/25 at 11:31 am . Medical Director indicated that he was notified by Nurse #5 of medication error. Medical Director indicated that Resident #14 did not have any negative outcomes from receiving the 2 units of Humalog Insulin.

Interview with the Administrator was conducted on 4/17/25 at 12:16 pm. The Administrator indicated that he would require each nurse and medication aide to administer medication to the right resident, per physician orders.

The facility provided the following corrective action plan.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
The physician was immediately notified, orders obtained to monitor blood sugars 1x that day, then at 6am for the next 2 days for Resident #14 . The resident had no ill effects from the medication. The nurse is no longer employed at facility.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
The DON reviewed all residents Medication

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F 760	Continued From page 23	F 760		

Administration Record (MARs) on the nurse's (Nurse #5) assignment. No others had orders for blood glucose monitoring or insulin orders were on that assignment. The supervisor also reviewed other residents had no medication administration concerns. No other residents were affected.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
Education was provided from 10/26/24 through 10/28/24, to the licensed nurses and medication aides by the DON on the medication policy as well as education by pharmacy on proper medication administration. This policy consists of ensuring the triple check is completed and the correct resident is identified prior to medication administration methods including checking the residents' pictures, ensuring the room number matches the MAR and asking the residents name as well as asking other staff members for identification if not sure. Audit/review of medication administration is observed each am in morning meeting to monitor for actual/potential medication issues and new orders are reviewed for accuracy. Pharmacy notified on 10/28/24. Pharmacy visits the community monthly and completes medication observations with nurses (ensuring the correct resident is part of the monitoring process). The error was reviewed by the interdisciplinary team on 10/28/24, and this plan of correction was developed and implemented. Results of medication administration reviews/audits as well as pharmacy observation results are taken to monthly QAPI by the Director of Nursing starting 10/28/24. The Medical Director was notified by the Director of Nursing on 10/28/24.

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F 760	Continued From page 24 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. Results of the reviews/audits will be reported to the QAPI committee monthly. Additional audits may be completed based upon the level of compliance. The review results/audits will be required by the Quality Assurance Committee until such time that consistent substantial compliance has been achieved as determined by the committee Allegation of compliance 10/29/24. The facility's corrective action plan was validated by the following: On 04/17/25 the facility's plan of correction was validated upon review of the sign-in sheets for in-service education provided to all licensed nurses and medication aides on proper medication administration per medication policy and procedures. Review of the monitoring audits revealed they were completed as stated in the corrective action plan with no concerns identified. Interviews conducted with licensed nurses and medication aides aides revealed they had received education on proper medication administration. In addition, the plan of correction was validated upon review of the sign-in sheets for in-service education provided to all licensed nurses and certified nurse aides on proper medication administration. Medication Administration was observed as part of the recertification survey and no errors were noted.The compliance date of 10/29/24 for the	F 760		

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F 760	Continued From page 25 corrective action plan was validated.	F 760		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by:	F 836		5/7/25

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F 836	Continued From page 26 Based on record review and staff interviews, the facility failed to verify that 1 of 5 nurses, Nurse #4, had a valid, non-expired nursing license. The facility was responsible for ensuring that all nursing staff employed had current licenses. The findings included: Review of facility's workers directory on 04/15/25 and an interview with the Human Resource Manager on 04/15/25 at 2:32 PM revealed Nurse #4 was hired on 11/05/96 as a Licensed Practical Nurse (LPN) and was still employed by the facility. A review of Nurse #4's LPN license with the North Carolina Board of Nursing (NCBON) revealed her LPN license approval date was 10/07/1988 with an expiration date of 04/30/24. A phone interview was conducted on 04/15/25 at 11:38 AM with Nurse #4. She verified she had been working full time and worked the 300 hall at the facility. She stated the last day she worked at the facility was 03/09/25. She explained she was not aware her license had expired until she received a letter from the state Board of Nursing. She further explained that she was not working from 04/16/24 through 07/08/24 because she had surgery along with chemotherapy and had not thought about the renewal of her nursing license. The facility had not notified her that her license had expired, and she did not recall receiving an email from the NCBON to remind her it was time to renew. She verified she had not worked since she found out her license had expired. Nurse #4 indicated she checked her personal email daily however did not recall seeing the email.	F 836	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. It is the policy of WhiteStone: A Masonic & Eastern Star Community that employees who require a license, certification, or registration to perform their duties must present such verification with their application for employment. A copy of recertifications (e.g., annual, bi-annual, etc., as applicable) must be presented to the human resources director/designee upon receipt of such recertifications and prior to the expiration of current licensure, certification, and/or registration. A copy of the recertification must be filed in the employee's personnel record. We submit that the facility will continue in this effort as follows. 1. As it relates to correcting the observed deficiency associated with Nurse 4: a. On 3/10/2025 the facility became aware of the lapse in Nurse 4's license, and Nurse 4 was removed from the schedule	

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F 836	Continued From page 27 An interview was conducted on 04/15/25 at 2:06 PM with the Director of Nursing (DON). She stated the facility did keep track of nurse licensures and notified the employee to renew 30 days prior to expiration date. She further stated the human resource department was responsible for notification. She explained she was not aware Nurse #4's license had expired until the employee herself had notified her in March 2025. She immediately removed Nurse #4 from the schedule and told her to make them aware when her license was renewed. She stated she did not know what happened in this case and how it was missed. It was expected nursing licenses would be kept current. An interview was conducted on 04/15/25 at 2:32 PM with the Human Resource Director. She stated since 2021 the system they use for payroll keeps track of nursing license and date of expiration. She explained that the nurse license was uploaded into the system during the hiring process then 30 days prior to the expiration date the system would send an automatic email to the employee, DON, Staff Development Nurse (SDC), and the Administrator making them aware the employee license would be expiring in 30 days, and the employee would need to submit the new license to the human resource department. She stated she did not know what happened with Nurse #4's case. She stated the current DON had not been in her position long prior to the license expiring, however the DON was the former SDC Nurse. An interview was conducted on 04/15/25 at 1:55 PM with the Administrator. He stated the facility did not keep track of nursing licensures and that it was the employee's responsibility to keep up with	F 836	on 3/10/2025. b. Nurse 4 is currently in the process of renewing her license with the Board of Nursing, and Nurse 4 will remain off the schedule until the license has been renewed. 2. The facility has established the following action steps in attempts to identify residents that might have been affected by similar conditions and to also ensure compliance with the rule, a. All other licensed and certified staff (FT, PT, PRN) were audited by the Director of Human Resources on 5/5/2025 to ensure that their licensure was valid and current, and that the facility had a copy of the licensure in each staff's file. Results of this audit showed all other licensed and certified staff's licensures were valid and current. 3. To prevent future problems associated with this rule the facility submits it will do the following: a. All Nurses and CNAs (FT, PT, PRN, and Agency) will receive education from the Director of Nursing and/or Designee regarding their requirements of maintaining active and valid licensure. Education to include that a copy of their current licensure should be provided to Human Resources for recordkeeping. This education will be added to the facility's new staff orientation, annual staff training, and as needed. Any staff that have not received the education by the stated date of compliance will be required to receive the education prior to their next	

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F 836	Continued From page 28 it.	F 836	scheduled shift. b. Education was provided by the Administrator to all Human Resources Staff on licensure/certification requirements, identifying Staff who will need to update their licensure/certification, and providing the Administrator and Director of Nursing with a monthly list of all licensed/certified Staff on the 1st of each month who have an upcoming renewal. c. Upon receipt of this document, the Administrator, Director of Nursing, and/or Designee will notify the staff to ensure that licensure/certification is renewed timely. Staff will be directed to provide Human Resources with a copy of their renewed licensure at the time of receipt. Human Resources will reconcile the monthly list and notify the Administrator and Director of Nursing of the received licensure/certification. d. At the end of the month, the Administrator or Director of Nursing will validate that all renewals have been accounted for. If staff have not renewed their licensure prior to expiration, they will be removed from the schedule until the time comes when they have renewed their license. 4. To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will audit five staff members licensure weekly for four weeks, three staff members weekly for four weeks, and one staff member weekly for four weeks to verify that their licensure is active and documented within	

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F 836	Continued From page 29	F 836	their employee record. 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. 5. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 5/7/2025.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		5/7/25

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(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 31 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a medical record was accurate regarding the Treatment Administration Record (TAR). This was for 1 of 1 resident in the area of hearing aid application (Resident #16) who was reviewed for medical record accuracy. Findings included: A review of the April 2025 Treatment Administration Record revealed documentation of Resident #16's right hearing aid being on every AM from 4/1/25 through 4/7/25, 4/11/25, 4/12/25, and 4/14/25. Further review of the April 2025 MAR revealed Nurse #2 had documented on the TAR the resident's hearing aid was on 4/1/25, 4/2/25, 4/4/25, 4/6/25, 4/11/25, and 4/14/25. On 4/16/25 at 1:49 PM an interview was conducted with Nurse #2 who stated she had worked for the facility for the past six months and had never seen Resident #16 with hearing aids. In a follow up phone interview with Nurse #2 on 4/17/25 at 10:13 AM, she stated if she had checked the box indicating the hearing aid was on then that was a mistake on her part. An interview with the Director of Nursing was held on 4/17/25 at 10:32 AM at which time she stated the staff should not document a task was completed if they had not done it. An interview with the Administrator was conducted on 4/17/25 at 12:08 PM who stated staff should not have checked boxes that they put	F 842	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. It is the policy of WhiteStone: A Masonic & Eastern Star Community that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. We submit that the facility will continue in this effort as follows. 1. As it relates to correcting the observed deficiency associated with resident 16: a. As the facility is in the process of replacing Resident 16's hearing aids, the current orders for hearing aids have been	

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F 842	Continued From page 32 hearing aids on for Resident #16 if they had not.	F 842	placed on hold. Once replacements have arrived, the facility will restart Resident 16's orders and monitor hearing aid application, removal, and storage via Resident 16's Treatment Record. 2. The facility has established the following action steps in attempts to identify residents that might have been affected by similar conditions and to also ensure compliance with the rule, a. All other Residents with orders for hearing aids were audited by the Director of Nursing and/or Designee on 5/2/2025 to verify that they were accounted for. Also, a thirty-day lookback audit was completed on 5/2/2025 for the Residents' Treatment Records to ensure they consisted of documentation to monitor hearing aid application, removal, and storage. The results of this audit showed that all the other hearing aids were accounted for and that the documentation of application, removal, and storage was complete. 3. To prevent future problems associated with this rule the facility submits it will do the following: a. All Licensed Nurses (FT, PT, PRN, and Agency) will receive education by the Director of Nursing and/or Designee on medical record documentation accuracy, including to ensure hearing aids are present and accounted for regarding application, removal, and storage. Education to include that if hearing aids are not accounted for, the record should not be signed and the process for a	

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F 842	Continued From page 33	F 842	missing item should be initiated. This education will be added to the facility's new staff orientation, annual staff training, and as needed. Any staff that have not received the education by the stated date of compliance will be required to receive the education prior to their next scheduled shift. 4. To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will audit five Residents Treatment Records weekly for four weeks, three Residents Treatment Records for four weeks, and two Residents Treatment Records for four weeks to ensure that hearing aids are accounted for, and that the documentation supports the application, removal, and storage. 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. 5. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 5/7/2025.	