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	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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415 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 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 [DATE] 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 [DATE] 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 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. (continued on next page)

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 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, 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. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-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 [DATE] 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 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 [DATE] 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 roiagnom on [DATE]. 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 assessment and was not available for interview. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 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 roiagnom on [DATE] 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 neurologically no focal neurological sign. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 sling sliding after Resident #399 was sent to the emergency roiagnom on [DATE]. 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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49295 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 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 [DATE] 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 [DATE] 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 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. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Pharmacy Consultant was 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 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. (continued on next page)

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	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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 corrective action plan was validated.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 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 [DATE] and an interview with the Human Resource Manager on [DATE] at 2:32 PM revealed Nurse #4 was hired on [DATE] 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 [DATE] with an expiration date of [DATE]. A phone interview was conducted on [DATE] 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 [DATE]. 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 [DATE] through [DATE] 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. An interview was conducted on [DATE] 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 [DATE]. 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 [DATE] 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. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on [DATE] 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 it.