STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Whitestone Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 370 White Stone Corner Road Stroudsburg, PA 18360	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, facility investigative reports select facility policies, and American Heart Association guidelines and staff interviews it was determined the facility failed to provide prompt cardio pulmonary resuscitation intervention consistent with a resident's advanced directives for one resident (Resident CR1) out of five residents sampled. This failure placed 33 facility residents of 86 residents residing in the facility, desiring cardiopulmonary resuscitation (CPR), in immediate jeopardy to their health and safety with the potential for death because of a similar occurrence. (Resident's CR1 ,3,4,5,6,7,8,9,10,11,12,13,14, 15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32, 33 and 34. Findings include: Review of the facility's policy and procedure titled Cardiopulmonary Resuscitation (CPR is an emergency treatment that's done when someone's breathing or heartbeat has stopped) last reviewed by the facility [DATE], revealed, licensed nurses, respiratory therapists and van drivers will hold active CPR certificates for healthcare providers by an American Heart Association (AHA) approved provider, wherein course content requires an in-person skills verification. Courses completed in on-line only format are not acceptable. CPR will be provided to all residents/patients who experience cardiopulmonary arrest unless one or more of the following is present: -A valid Advanced directive (a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) or POLST (Provider Orders for Life-Sustaining Treatment a type of advance directive that communicates your wishes for emergency medical treatment when you can't speak for yourself requesting withholding or providing CPR) -Documented verbal wishes by the resident /surrogate decision maker indicating the desire to be DNR (do not resuscitate means the resident does not want to be resuscitated if they suddenly go into cardiac arrest or stop breathing) but Physician order is pending -Dependent Lividity, rigor mortis (sign of death characterized by stiffening of the limbs), decapitation (separation of the head from the body) or transection, (cutting across or through a structure). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER: Whitestone Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 370 White Stone Corner Road Stroudsburg, PA 18360	

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resuscitative efforts which have been initiated may be withdrawn if any of the documents listed above are discovered and efforts to that point have been unsuccessful. In the event the resident does not meet any of the above criteria, resuscitative efforts shall be initiated according to American Heart Association guidelines. 1. Activate the emergency response team: -the resident should not be left alone -if you alone with the victim, call out for help -if someone is nearby, instruct them to dial 911 (emergency services) immediately -in the event that help is not available, call 911 and retrieve emergency cart prior to starting CPR, return as soon as possible. 2. Use an AED, Automated External Defibrillator, is a portable device that can help save someone's life during sudden cardiac arrest. It delivers an electric shock to the heart to restore its normal rhythm) as soon as possible if one is available. If no AED is available, continue the cycle of compressions. 3. Continue CPR efforts until pulse is restored, EMS arrives, an onsite physician or nurse practitioner instructs otherwise, or until the team can no longer continue due to exhaustion. According to American Heart Association guidelines presumptive Signs of Death are as follows: The patient is unresponsive. The patient has no respirations. The patient has no pulse. The patient's pupils are fixed and dilated. The patient's body temperature indicates hypothermia: skin is cold relative to the patient's baseline skin temperature. The patient has generalized cyanosis (bluish skin color due to decreased amounts of oxygen). AHA guidelines for Conclusive (irreversible) Signs of Death are as follows: There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	While these signs of irreversible death would not be expected to be seen in most practice settings, the American Heart Association also includes the following irreversible signs of death: decapitation (separation of the head from the body). decomposition (decay or putrefaction of the body); rigor mortis (stiffness of the limbs and body that develops 2 - 4 hours after death and may take up to 12 hours to fully develop). Clinical record review for Residents 3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28, 29,30,31,32,33,34 and CR1 had current Physicians orders regarding code status to receive CPR in the event of cardiac arrest. Interview conducted on [DATE], at 11:00 AM with Employee 1 nurse aide revealed on [DATE], at 6:30 PM she picked up Resident CR1's dinner tray from (his/her) room. The resident was grey and not responding. Employee 1 went to the door and yelled for the nurse. Employee 2 RN responded to the room, then left the room and returned with a chart. Employee 2 informed nurse aide, Employee 1, that Resident CR1 was a DNR. RN Employee 2, and Employee 1 nurse aide left resident's room. After 7:00 PM, Employee 3 RN arrived on the nursing unit/t, checked Resident CR1's electronic medical record and told Employee 1 nurse aide to get the emergency cart and bring it to Resident CR1's room. Employee 1 nurse aide and Employee 3 RN and Employee 2 RN initiated CPR and continued until paramedics arrived at 7:10 P.M. and took over CPR. Review of Resident CR1's clinical record revealed admission to the facility on [DATE], with diagnoses including esophageal cancer, hypertension, and Atrial fibrillation (an abnormal heart rhythm, characterized by rapid and irregular beating of the heart). Review of Resident CR1's clinical record failed to reveal an MDS assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) available for review at the time of the survey. Review of Resident CR1's clinical record revealed a physician order dated [DATE], identifying the resident was to receive CPR (emergency lifesaving procedure performed when the heart stops beating as immediate CPR can double or triple chances of survival after cardiac arrest) in the event of cardiac arrest. This physician's order for CPR was confirmed by the RN (registered nurse) Supervisor, Employee 2 on [DATE]. Review of the facility's investigation documentation dated [DATE], at approximately 6:35 P.M., revealed Employee 1, nurse aide, was picking up the resident's dinner tray and found Resident CR1 unresponsive in (his/her) bed. She called for staff help. Employee 2 the RN 7:00 AM to 7:00 PM Supervisor responded to the room and found Resident CR1 pulseless and without spontaneous respirations. Employee 2, RN Supervisor went to the nursing station and picked up a physical chart (binder containing resident information) from the chart rack, noting the resident had a code state of do not resuscitate, (DNR). The physical resident's chart/binder was identified only by room number. CPR was not initiated by nursing staff for Resident CR1 at that time. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of the facility's investigation revealed Employee 2, (7:00 AM to 7:00 PM) RN Supervisor left the room, went back to the nurse's station, and called the oncoming (7:00 PM to 7:00 AM) RN Supervisor, Employee 3 to ask for advice concerning calling the deceased resident's family. At that time, he identified Resident 2 as the deceased resident, not Resident CR1. He then called Resident 2's family informing them of their family member's death. Employee 2, RN 7:00 AM to 7:00 PM Supervisor, incorrectly notified Resident 2's family of (his/her) death after failing to accurately identify resident CR1's code status. According to the facility's investigation at approximately 7:00 PM, Employee 3, RN Supervisor entered the building and observed Resident 2 ambulating in (his/her) wheelchair in the hallway. Employee 3 RN then checked the medical record and discovered that Resident CR1 was noted as full code status. CPR was initiated by Employee 3 RN and Employee 1 nurse aide at 7:05 PM, 30 minutes after Resident CR1 was found to be unresponsive. Emergency Medical Services, (EMS 911) was called. Review of nursing documentation dated [DATE], at 9:11 P.M. revealed, at 7:10 PM the paramedics arrived and took over CPR. At 7:50 PM the paramedics contacted the hospital emergency room and obtained an order to stop CPR. Resident CR1 was pronounced dead at 7:50 PM. Review of Employee 3, RN Supervisor's statement dated [DATE] (no time indicated) indicated, I received a phone call at 6:42 PM ([DATE]) as I was driving into work from Employee 2 RN Supervisor, asking my advice on what to say to the family (of the resident that he identified as deceased , Resident 2). When I arrived to work at 7:00 PM and observed Resident 2 very much alive and well, sitting in the activity room. Employee 2, RN Supervisor was at the nurse's station and informed me that he identified Resident CR1's code status incorrectly and it was Resident CR1 that had passed, not Resident 2. Employee 2, RN Supervisor, informed me that Resident CR1 was a full code (initiate CPR if no pulse or respirations). I directed Employee 2, RN Supervisor, and Employee 1, nurse aide to bring the emergency cart to the room and begin CPR. I called 911 at 7:08 PM. EMS arrived at 7:17 PM. EMS continued CPR until the local medical center was contacted and received an order to stop CPR at 7:50 P.M. Review of a witness statement by Employee 2, RN Supervisor, dated [DATE] (no time indicated) revealed, I was called to Resident CR1's room at 6:40 P.M by Employee 1 nurse aide. I assessed Resident CR1 and noted no pulse or respirations. The resident was cold to touch and pale. I then walked back to the nurse's station and inadvertently grabbed the wrong chart. The resident (Resident 2) in this chart was noted as a DNR. I then called Resident 2's family to inform them that Resident 2 had died . I also called the resident's Physician to inform him of the incident. At 7:00 PM. I realized that I had grabbed the wrong chart. I then went into the electronic medical record and confirmed that Resident CR1's code status was a full code. At 7:01 PM Employee 3 (7 PM to 7 AM RN Supervisor) arrived on the floor, I told her what happened. I grabbed the emergency cart, ran to the resident's room and with Employee 1 nurse aide initiated, Cardiopulmonary Resuscitation to Resident CR1. The facility failed to provide emergency care in accordance with the established code status of a resident who was identified as full code. Facility staff failed to obtain Resident C1's correct code status, resulting in a 30-minute delay in initiating cardiopulmonary resuscitation (CPR) for the resident during a medical emergency. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to interview with the Nursing Home Administer (NHA), Employee 3 RN Supervisor, and documentation in the clinical record, the RN did not to initiate CPR because the facility's licensed and professional nursing staff did not verify the resident's identity and correct code status to make the determination to initiate CPR. Interview with the facility NHA on [DATE], at P.M., confirmed that Employee 2 RN Supervisor did not identify Resident CR1 or resident's code status prior to his decision not to initiate CPR in an effort to revive resident. Further, she could not state why Employee 2 RN was unaware of the procedure for identification of residents and their code status at the time of the incident. The Nursing Home Administrator indicated that Employee 2 was terminated as a result of the failure to correctly identify the resident's code status and perform life sustaining measures. This delay by facility staff to perform life sustaining measures of CPR may have contributed to Resident CR1's subsequent death. The failure to follow proper emergency response protocols and accurately verify the resident's code status placed the resident in immediate jeopardy and represents a systemic failure to ensure the health and safety of residents requiring emergency care. Immediate Jeopardy was identified and called on [DATE], at 12:00 PM for the facility's failure to identify Resident CR1's proper code status and timely administration of CPR to a resident beginning on [DATE], at 6:30 PM placing residents' health and safety at serious risk. This deficiency is cited as past non-compliance. The IJ template was provided to the facility at 12:00 PM and an immediate plan of correction was requested and received on [DATE]. The plan included: -Education was completed [DATE], and is being the facility completed reeducation to staff on [DATE], after the incident, but the root cause was not identified as to why the RN went to the paper chart instead of the electronic medical record for identification and code status information. The paper chart did not contain this information so after immediate jeopardy was identified, education on where to find the identifying information needed to be conducted by the end of the day [DATE]. -Immediate training for licensed staff on the importance of verifying code status and providing CPR as indicted in the electronic medical record. The education provided included locating Physicians orders for code status in the electronic medical record. Staff demonstrated the proper location of Physicians orders for code status. Per CMS guidelines, the facility will honor code status documented in the resident's electronic medical record. -Staff CPR certifications were verified to be current on [DATE]. -Reviewed all resident's charts to ensure all residents have a Physician's order in the electronic medical record for code status by [DATE], at 8:00PM. -A code blue drill will be conducted every shift for 24 hours completed by [DATE]. -Licensed staff will be educated regarding, CPR policies and procedures to include, 2 licensed nurses to verify the right resident and right code status in the electronic medical record prior to initiating CPR by [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The physical residents' paper charts will be removed from the nursing station by [DATE]. The action plan was completed prior to the start of the 11:00 PM to 7:00 AM shift on [DATE], ensuring that staff received the necessary training before beginning their duties. The results of audits and drills were anticipated to be reviewed at QAPI (Quality Assurance Performance Improvement) meeting on [DATE], for monitoring of facility CPR policy and procedure. The Immediate Jeopardy was lifted on [DATE], at 5:00 PM upon receipt of the facility's immediate action plan and evidence of its implementation was verified. The facility's compliance date was [DATE]. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, select facility policy and reports, and employee job descriptions and staff interview it was determined the facility's administration failed to effectively use its resources to promote resident safety by failing to implement established procedures to provide timely cardiopulmonary resuscitation (CPR) in the event of cardiac arrest according to a resident's advanced directive for one out of five sampled residents (Resident CR1). Findings included: Review of the facility's policy and procedure titled Cardiopulmonary Resuscitation (CPR is an emergency treatment that's done when someone's breathing or heartbeat has stopped) last reviewed by the facility [DATE], revealed, licensed nurses, respiratory therapists and van drivers will hold active CPR certificates for healthcare providers by an American Heart Association (AHA) approved provider, wherein course content requires an in-person skills verification. Courses completed in on-line only format are not acceptable. CPR will be provided to all residents/patients who experience cardiopulmonary arrest unless one or more of the following is present: -A valid Advanced directive (a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) or POLST (Provider Orders for Life-Sustaining Treatment a type of advance directive that communicates your wishes for emergency medical treatment when you can't speak for yourself requesting withholding or providing CPR) -Documented verbal wishes by the resident /surrogate decision maker indicating the desire to be DNR (do not resuscitate means the resident does not want to be resuscitated if they suddenly go into cardiac arrest or stop breathing) but Physician order is pending -Dependent Lividity, rigor mortis (sign of death characterized by stiffening of the limbs), decapitation (separation of the head from the body) or transection, (cutting across or through a structure). Resuscitative efforts which have been initiated may be withdrawn if any of the documents listed above are discovered and efforts to that point have been unsuccessful. In the event the resident does not meet any of the above criteria, resuscitative efforts shall be initiated according to American Heart Association guidelines. 1. Activate the emergency response team: -the resident should not be left alone -if you alone with the victim, call out for help (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-if someone is nearby, instruct them to dial 911 (emergency services) immediately -in the event that help is not available, call 911 and retrieve emergency cart prior to starting CPR, return as soon as possible. 2. Use an AED, Automated External Defibrillator, is a portable device that can help save someone's life during sudden cardiac arrest. It delivers an electric shock to the heart to restore its normal rhythm) as soon as possible if one is available. If no AED is available, continue the cycle of compressions. 3. Continue CPR efforts until pulse is restored, EMS arrives, an onsite physician or nurse practitioner instructs otherwise, or until the team can no longer continue due to exhaustion. According to American Heart Association guidelines presumptive Signs of Death are as follows: The patient is unresponsive. The patient has no respirations. The patient has no pulse. The patient's pupils are fixed and dilated. The patient's body temperature indicates hypothermia: skin is cold relative to the patient's baseline skin temperature. The patient has generalized cyanosis (bluish skin color due to decreased amounts of oxygen). AHA guidelines for Conclusive (irreversible) Signs of Death are as follows: There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin). While these signs of irreversible death would not be expected to be seen in most practice settings, the American Heart Association also includes the following irreversible signs of death: decapitation (separation of the head from the body). decomposition (decay or putrefaction of the body); rigor mortis (stiffness of the limbs and body that develops 2 - 4 hours after death and may take up to 12 hours to fully develop). Interview conducted on [DATE], at 11:00 AM with Employee 1 nurse aide revealed on [DATE], at 6:30 PM she picked up Resident CR1's dinner tray from (his/her) room. The resident was grey and not responding. Employee 1 went to the door and yelled for the nurse. Employee 2 RN responded to the room, then left the room and returned with a chart. Employee 2 informed nurse aide, Employee 1, that Resident CR1 was a DNR. RN Employee 2, and Employee 1 nurse aide left resident's room. After 7:00 PM, Employee 3 RN arrived on the nursing unit/t, checked Resident CR1's electronic medical record and told Employee 1 nurse aide to get the emergency cart and bring it to Resident CR1's room. Employee 1 nurse aide and Employee 3 RN and Employee 2 RN initiated CPR and continued until paramedics arrived at 7:10 P.M. and took over CPR. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident CR1's clinical record revealed admission to the facility on [DATE], with diagnoses including esophageal cancer, hypertension, and Atrial fibrillation (an abnormal heart rhythm, characterized by rapid and irregular beating of the heart). Review of Resident CR1's clinical record failed to reveal an MDS assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) available for review at the time of the survey. Review of Resident CR1's clinical record revealed a physician order dated [DATE], identifying the resident was to receive CPR (emergency lifesaving procedure performed when the heart stops beating as immediate CPR can double or triple chances of survival after cardiac arrest) in the event of cardiac arrest. This physician's order for CPR was confirmed by the RN (registered nurse) Supervisor, Employee 2 on [DATE]. Review of the facility's investigation documentation dated [DATE], at approximately 6:35 P.M., revealed Employee 1, nurse aide, was picking up the resident's dinner tray and found Resident CR1 unresponsive in (his/her) bed. She called for staff help. Employee 2 the RN 7:00 AM to 7:00 PM Supervisor responded to the room and found Resident CR1 pulseless and without spontaneous respirations. Employee 2, RN Supervisor went to the nursing station and picked up a physical chart (binder containing resident information) from the chart rack, noting the resident had a code state of do not resuscitate, (DNR). The physical resident's chart/binder was identified only by room number. CPR was not initiated by nursing staff for Resident CR1 at that time. Further review of the facility's investigation revealed Employee 2, (7:00 AM to 7:00 PM) RN Supervisor left the room, went back to the nurse's station, and called the oncoming (7:00 PM to 7:00 AM) RN Supervisor, Employee 3 to ask for advice concerning calling the deceased resident's family. At that time, he identified Resident 2 as the deceased resident, not Resident CR1. He then called Resident 2's family informing them of their family member's death. Employee 2, RN 7:00 AM to 7:00 PM Supervisor, incorrectly notified Resident 2's family of (his/her) death after failing to accurately identify resident CR1's code status. According to the facility's investigation at approximately 7:00 PM, Employee 3, RN Supervisor entered the building and observed Resident 2 ambulating in (his/her) wheelchair in the hallway. Employee 3 RN then checked the medical record and discovered that Resident CR1 was noted as full code status. CPR was initiated by Employee 3 RN and Employee 1 nurse aide at 7:05 PM, 30 minutes after Resident CR1 was found to be unresponsive. Emergency Medical Services, (EMS 911) was called. Review of nursing documentation dated [DATE], at 9:11 P.M. revealed, at 7:10 PM the paramedics arrived and took over CPR. At 7:50 PM the paramedics contacted the hospital emergency room and obtained an order to stop CPR. Resident CR1 was pronounced dead at 7:50 PM. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Employee 3, RN Supervisor's statement dated [DATE] (no time indicated) indicated, I received a phone call at 6:42 PM ([DATE]) as I was driving into work from Employee 2 RN Supervisor, asking my advice on what to say to the family (of the resident that he identified as deceased , Resident 2). When I arrived to work at 7:00 PM and observed Resident 2 very much alive and well, sitting in the activity room. Employee 2, RN Supervisor was at the nurse's station and informed me that he identified Resident CR1's code status incorrectly and it was Resident CR1 that had passed, not Resident 2. Employee 2, RN Supervisor, informed me that Resident CR1 was a full code (initiate CPR if no pulse or respirations). I directed Employee 2, RN Supervisor, and Employee 1, nurse aide to bring the emergency cart to the room and begin CPR. I called 911 at 7:08 PM. EMS arrived at 7:17 PM. EMS continued CPR until the local medical center was contacted and received an order to stop CPR at 7:50 P.M. Review of a witness statement by Employee 2, RN Supervisor, dated [DATE] (no time indicated) revealed, I was called to Resident CR1's room at 6:40 P.M by Employee 1 nurse aide. I assessed Resident CR1 and noted no pulse or respirations. The resident was cold to touch and pale. I then walked back to the nurse's station and inadvertently grabbed the wrong chart. The resident (Resident 2) in this chart was noted as a DNR. I then called Resident 2's family to inform them that Resident 2 had died . I also called the resident's Physician to inform him of the incident. At 7:00 PM. I realized that I had grabbed the wrong chart. I then went into the electronic medical record and confirmed that Resident CR1's code status was a full code. At 7:01 PM Employee 3 (7 PM to 7 AM RN Supervisor) arrived on the floor, I told her what happened. I grabbed the emergency cart, ran to the resident's room and with Employee 1 nurse aide initiated, Cardiopulmonary Resuscitation to Resident CR1. The facility failed to provide emergency care in accordance with the established code status of a resident who was identified as full code. Facility staff failed to obtain Resident C1's correct code status, resulting in a 30-minute delay in initiating cardiopulmonary resuscitation (CPR) for the resident during a medical emergency. According to interview with the Nursing Home Administer (NHA), Employee 3 RN Supervisor, and documentation in the clinical record, the RN did not to initiate CPR because the facility's licensed and professional nursing staff did not verify the resident's identity and correct code status to make the determination to initiate CPR. Interview with the facility NHA on [DATE], at P.M., confirmed that Employee 2 RN Supervisor did not identify Resident CR1 or resident's code status prior to his decision not to initiate CPR in an effort to revive resident. Further, she could not state why Employee 2 RN was unaware of the procedure for identification of residents and their code status at the time of the incident. The Nursing Home Administrator indicated that Employee 2 was terminated as a result of the failure to correctly identify the resident's code status and perform life sustaining measures. This delay by facility staff to perform life sustaining measures of CPR may have contributed to Resident CR1's subsequent death. The failure to follow proper emergency response protocols and accurately verify the resident's code status placed the resident in immediate jeopardy and represents a systemic failure to ensure the health and safety of residents requiring emergency care. These failures placed residents who desired CPR in the event of cardiac arrest in immediate jeopardy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Whitestone Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 370 White Stone Corner Road Stroudsburg, PA 18360	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	As a result of the failure of licensed staff to promptly initiate CPR for a resident, immediate jeopardy to the health and safety and substandard quality of care was identified at the facility on [DATE]. A review of the job description for the Administrator of the facility revealed the Administrator leads and directs the overall operations of the facility in accordance with the community, policies and procedures, customer, and resident needs and both state and federal guidelines. To maintain excellent care for the residents/patients and achieve the facility's business objective. The Administrator delegated the administrative authority, responsibility, and accountability necessary for carrying out the assigned duties. The administrator is responsible for carrying out the operational core responsibilities established by the company and facility. The NHA is responsible for the oversite of the resident care policies established by the facility. A review of the job description for the Director of Nursing (DON) indicated it is the responsibility of the DON is to organize, develop and direct the overall operations of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that govern the facility. The Director of Nursing is to work directly with the Administrator and the Medical Director to ensure the highest degree of quality of care is always maintained for each resident. The Director of Nursing is delegated the administrative authority, responsibility, and accountability necessary for carrying out the assigned duties. In the absence of the Medical Director, the DON is responsible to carry out the resident care policies established by the facility. The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Quality of Life (F678) 483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives, revealed the Administrator and DON failed to fulfill the essential job duties for ensuring the health and safety of the residents and adherence to regulatory guidelines. Refer F678 28 Pa. Code: 201.14 (a) Responsibility of licensee 28 Pa. Code: 201.18 (b)(1)(e)(1) Management 28 Pa. Code:211.12(a)(b)(c)(d)(1) Nursing Services