STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396130	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitestone Care Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement care and services, consistent with professional standards of practice, to prevent pressure ulcer development for one resident out of two sampled. (Resident 1). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i. e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with diagnoses that included Fournier gangrene (a rare, life-threatening, and rapidly progressive infection that affects the soft tissue and skin of the genital area and perineum), Type 2 diabetes (body has trouble controlling blood sugar and using it for energy) with diabetic chronic kidney disease (loss of kidney function), and cerebral infarction (stroke). Review of Resident 1's Admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 28, 2024, revealed the resident was severely cognitively impaired, required substantial/maximal assistance for rolling in bed, required total staff assistance for activities of daily living, required total staff assistance for transfers, and was at-risk for the development of pressure ulcers and injuries. (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility admission skin assessment titled Weekly Observation dated September 26, 2024, revealed the resident had new skin issues that included right arm bruising 15 cm x 7 cm, left arm bruising 5 cm x 12 cm, left hand bruise 5 cm x 5 cm, left leg redness 3 cm x 0.5 cm, left big toe scab 1 cm x 1 cm, 2nd toe scab 0.5 cm x 0.5 cm, right buttock Stage II pressure ulcer (partial-thickness skin loss, with loss of epidermis with or without true ulceration) 1 cm x 1 cm x 0.1 cm, and a sacral pressure ulcer Stage II 0.5 cm x 3 cm. Additional site description added the resident had a scrotal opening (previous wound vaccuum site) 8 cm x 1.5 cm x 1.7 cm, and a scrotal incision with sutures 1 cm x 4 cm. A review of Resident 1's plan of care initiated September 6, 2024, revealed the resident was identified with skin impairments related to decreased mobility, and infection. Planned interventions were to provide a pressure reducing mattress and wheelchair cushion, provide incontinence care after each incontinence episode, keep resident clean and dry as possible, minimize skin exposure to moisture, maintain the head of the bed at the lowest degree of elevation possible, and keep linens clean, dry and wrinkle-free. A revision was made on October 9, 2024, to include the addition of an air mattress, and to turn and reposition the resident every two hours. The goal was the resident's pressure ulcer would heal without complications. A review of a facility skin assessment titled Weekly Observation dated November 10, 2024, revealed the resident had existing skin issues that included an abrasion to the scrotal area. No areas of pressure injury were noted on the weekly skin assessment. A review of an outside consultant wound report dated November 12, 2024, two days after the facility performed the weekly skin assessment, the wound consultant reported that Resident 1 had a new area of an unstageable pressure wound (a wound is unstageable when the assessor cannot see the base of the wound to determine the severity or stage of the wound) of the left heel. The wound was described at 100% black eschar tissue (necrotic [dead] tissue often seen in pressure ulcers) with the peri-wound soft (surrounding area of the wound edge). Orders were to Xray the left heel to rule out osteomyelitis (infection in the bone), apply Betadine to left heel with a foam dressing, and to apply heel protectors to both heels at all times. Review of a nurses noted dated November 14, 2024, at 12:04 AM, two days after the facility received the wound consultation report, the nurses note stated the following: after reviewing consult from wound care, documentation revealed a new unstageable pressure area to left heel. Upon observation, a 4 cm x 3 cm unstageable area was visualized. The MD (physician) was notified. New treatment ordered. Prevalon boots (boot with a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure that stays in place for continuous pressure relief) added to care. Will continue to monitor. Review of the facility documentation titled Skin Integrity Events dated November 14, 2024, at 12:04 AM revealed a newly identified area of the left heel measuring 4 cm x 3 cm pressure ulcer classified as unstageable as the area was covered with eschar. The area was characterized as necrotic eschar. Prior to the pressure wound development on Resident 1's left heel, there was no documented evidence the facility had developed measures to prevent the development of a pressure sore of the resident's heel. The resident's care plan included no additional measures to prevent the development of pressure sores, such as pressure relief for the resident's heels, for a resident who was identified as at-risk for pressure sore development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide documented evidence the resident was turned and repositioned every 2 hours as indicated in the plan of care. There was no evidence that staff were elevating the resident's heels off the bed prior to the wound development. The facility failed to provide documented evidence the facility developed, implemented and provided preventative measures to prevent the development of a pressure ulcer on the resident's left heel. Interview with the Nursing Home Administrator (NHA) on December 19, 2024, at 2:00 PM confirmed the facility was unable to provide documented evidence that preventative measures were timely and consistently implemented to prevent the development of an unstageable pressure injury to the left heel for Resident 1. 28 Pa. Code 211.5 (f)(ii) Medical records 28 Pa. Code: 211.12 (c)(d)(1)(3)(5) Nursing Services